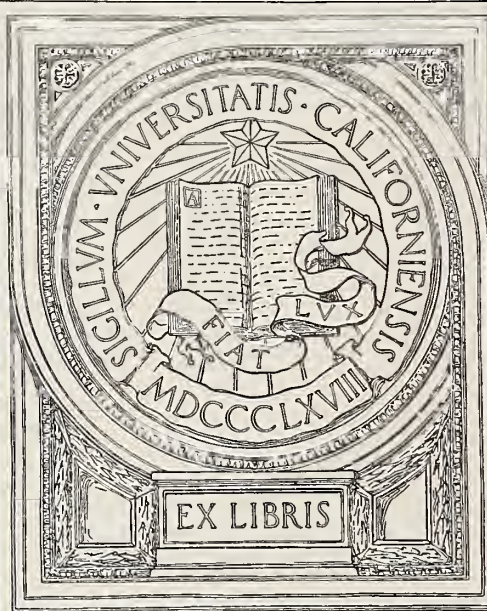


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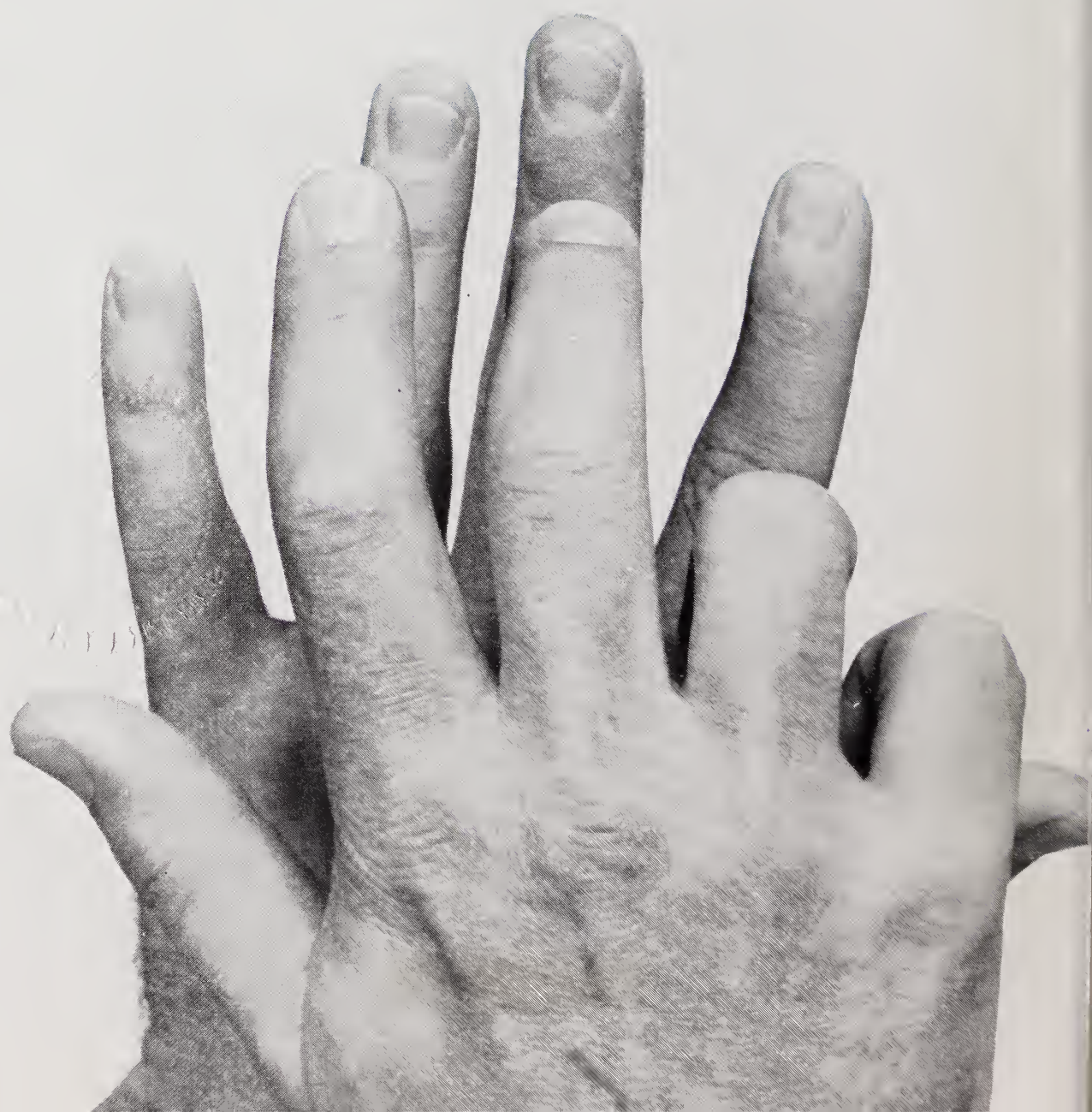
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Contents

Scientific Articles

THE MANAGEMENT OF ACUTE SURGICAL PROBLEMS IN CHILDREN Hugh B. Lynn, M.D.	3
MYXEDEMA AND COMA George R. Dillinger, M.D.	8
SELECTION OF AGENTS AND TECHNIQUES IN ANESTHESIA Paul W. Searles, M.D.	12
CURRENT ROLE OF HYPNOSIS IN MEDICINE Sheldon B. Cohen, M.D.	20
TRANSVAGINAL ANESTHESIA IN OBSTETRICS Joel D. Conner, M.D., and Preston Lea Wilds, M.D.	24

Special Article

LET'S START RAISING HELL Jenkin Lloyd Jones	30
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Editorials

SMOKING AND BRONCHOGENIC CARCINOMA	36
"IT IS BETTER TO LIGHT ONE CANDLE"	37
THE BATTEY STRAIN OF ATYPICAL ACID FAST BACILLI	37

Features

How Well Are We Telling Our Story?	11
President's Letter	39
Mental Health Page	41
Heart Page	43
Cancer Page	45
Physician's Bookshelf	47
Current Clinical Concepts	49

The Association

Deaths	50
Societies	50
Personals	51
MAG Board of Insurance and Economics Meeting, No- vember 18	52
Advertising Index	52A

Cover

Bronchial Lesion with Cilia Absent Composed Entirely of Atypical Cells (X 1200). Cover Photograph provided by Oscar Auerbach, M.D., Senior Medical Investigator, Veterans Administration Hospital, East Orange, New Jersey.

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THE MANAGEMENT OF ACUTE SURGICAL PROBLEMS IN CHILDREN

Hugh B. Lynn, M.D.,* *Rochester, Minnesota*

- ***The decision to carry out a procedure should be made solely on the basis of what is safest for the child.***

The emotions of the parents and the economics involved should not interfere with this decision.

WITHIN LIMITS, MORE HARM RESULTS from failure to make a prompt decision about the handling of an acute surgical condition than results from making the wrong diagnosis. While this statement is open to discussion, reflection upon your personal experiences and those of your colleagues will tend to support my contention.

Particularly in the cases of infants and small children, temporizing and indecision may lead to loss of the golden opportunity to operate while the patient's vitality and natural resources are still high.

In the emergency room an immediate blood count is advisable, with care to take into consideration the influence of dehydration upon the hemoglobin. Typing and cross-matching should be performed at the same time, since very few of the acute emergencies of infancy can be attempted safely without transfusion. In fact, once there is evidence of rehydration with progressive urinary output, the administration of blood probably is of greater supportive value than the giving of water and electrolyte solutions. When at all possible, attainment of a hemoglobin concentration of ten gm. per 100 ml. after hydration is desirable before administration of an anesthetic. The hematocrit determination may be most reassuring at this stage by indicating the state of hydration and restored blood volume.

In the infant or small child, dehydration is a major

hazard. Any physician should be able to recognize it if he examines his patient. In any good pediatric ward it is assumed that dehydration will be detected and steps taken to combat it immediately. The use of a cut-down is to be urged. Whenever surgery is a possibility, the use of small scalp and wrist veins and the insecure placement of needles in arms and ankles are not warranted. The extra few minutes spent in cannulating a large vein with a plastic tube ensures an adequate life line for preoperative preparation as well as for administration of fluids at operation and during the immediate postoperative period. An elastic bandage will permit free movement of the entire extremity, and provide protection as well as comfort (Figure 1).

It is important to reverse the loss of fluid and electrolytes as soon as possible; but it is rarely necessary, and usually not desirable, to restore the fluid balance completely in the time available before corrective surgery must be undertaken.

Rapid rehydration may not lead to pulmonary edema but most certainly will lead to the presence of free fluid in the peritoneal and pleural cavities as well as further puddling in loops of obstructed bowel. This fluid is useless and harmful.

It has been stated by many men working with infants that more harm results from over hydration than from under hydration. Determinations of serum sodium and of plasma chlorides and carbon dioxide provide the data most valuable in the planning of fluid therapy. Of course the first urine specimen

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Figure 1

Wrapping cut-down with elastic bandage permits free activity of the extremity.

should be analyzed with particular concern for the presence of sugar, albumin, and cellular elements.

Five per cent glucose in water, five per cent glucose in normal saline, and a combination of five per cent glucose in 0.2N saline are the commonly required solutions. A good rule of thumb for the average case is that one third of the required fluids, plus any loss by gastric suction or vomiting, should be normal saline. The addition of vitamins to the intravenous fluids is worth while (B complex and large doses of C, and in the newborn small amounts of K). As normal hydration is approached, the use of potassium chloride must be considered (3 mEq./kg./day being usually a safe basic figure).

In the presence of vomiting or abdominal distention the use of a nasogastric tube with intermittent suction is a necessity. Also, a tube is beneficial in many cases of prolonged emotional upset (crying, terrified screaming, and such, with air swallowing).

In selected cases a long double-lumen tube is indicated, but the majority of small patients will respond to the decompression produced by keeping the stomach empty of swallowed air and salivary juices and the normal or increased gastric secretions, as well as the intestinal contents that are regurgitated into the stomach. *To place the tube is not sufficient—it must work!* A poorly functioning tube is defi-

nately worse than none. It causes increased air swallowing, some irritation and increased salivation, and so on, and not only fails to relieve the condition it produces and the condition it is intended to combat, but seems to make vomiting easier and thereby enhances the possibility of aspiration, otitis, and other complications. It cannot be emphasized too strongly that a satisfactorily functioning tube, properly secured in place with the patient adequately restrained, is a most valuable aid. The patient should be restrained on his side (usually on the right side for gastric dependency), but it is important to change the position regularly and frequently.

It is advisable to flush the tube with normal saline every two or three hours; and the use of the intermittent type of suction apparatus seems to be the most satisfactory, although an aspirating syringe may serve quite adequately if employed regularly at short intervals.

Abdominal distention develops in many youngsters without intestinal lesions. After the initial rectal examination, much further relief may be achieved by repeated gentle rectal examinations which may produce flatus and fecal material, and at the very least will cause deep breathing and active change of position.

For critically ill infants, under certain circumstances, indwelling urinary catheters are advisable. A rack for urine bottles can be a simple apparatus for checking the output (Figure 2). Every hour the drainage tube is moved to a new bottle, thus affording an immediate comparison of the hourly output, color, concentration, and so on, and separating specimens for analyses in the laboratory as indicated.

Atmosphere A Consideration

As soon as the routine chores have been completed, a proper atmosphere for the sick infant is the next consideration. The addition of oxygen to the inspired air usually improves the patient's color and respiration, and eventually even the degree of abdominal distention may decrease. A concentration of not more than 35 to 40 per cent is advisable, especially in prematures. Prolonged use of oxygen may have deleterious effects and should be regarded with caution, particularly in the convalescent period. The beneficial effects of moisture in the air are well recognized. The ability of the oxygen tent or the incubator to regulate body temperature either up or down is of tremendous value.

To provide such an atmosphere for the tiny infant, the Isolette is the surgeon's best resource (Figure 3). Control of the temperature, oxygen, and humidity in a forced circulating filtered atmosphere protects the ill patient not only from other patients in the nursery but to a large extent from



Figure 2

Intermittent nasogastric suction apparatus (Gomco type), urine bottles in rack hung from bed frames, and calibrated infusion buret. Arm restraints are used in this situation.

the nurses and doctors who care for him. Further, the unexcelled visibility reduces the amount of handling required to monitor the patient and makes needed attention more prompt.

Elevation of the head of the bed tends to ease the respirations by reducing the pressure of abdominal viscera against the diaphragm. There are a few special circumstances in which the head-down position may be indicated, but these are not common and are certainly not comfortable. This is particularly true for infants, since their respiration is largely diaphragmatic.

The patient is now ready for any necessary roentgenologic or other essential laboratory studies that were not obtained in the admitting room. These should be kept to a minimum and performed as expeditiously as possible.

Antibiotics Secondary

Least important of all the early preparations, in my mind, is the beginning of antibiotic therapy. Certainly the presence of a possible infection or the likelihood of impending contamination through surgical manipulation warrants administration of appropriate broadly effective antibiotics. However, this is practically never the solution to an acute surgical emergency, and "giving them time to act" is never an excuse for further delay.

Much has been written about the optimal time for surgery. It is always wise to try to reduce an excessively high body temperature before administering an anesthetic, and it is always gratifying to see the respiration become less labored and the pulse become less rapid. However, no single sign is adequate as an indication of the proper moment for surgery. The use of a telethermometer to record rectal temperatures may be most helpful not only preoperatively but during surgery and early recovery. It must be remembered that some patients show remarkable improvement if allowed to have several hours of rest undisturbed by continual treatments and examinations.

It has been said that busy surgeons are always rushing things and tend to operate too soon. On the other hand, there is always the possibility the patient will deteriorate to a moribund state while he is being "gotten into shape" for the surgeon, and for this reason it seems obvious that the surgeon should participate in the care of the patient from the moment of admission to the hospital.

Once the preparations have been made, more or less in the order presented, it is probably safer to incline toward the surgeon's impatience. The general appearance of the patient is usually as good an indication as any single vital sign and certainly better than any single laboratory test, whose report is out of date almost at the moment received. The opinion



Figure 3

Isolette, probably the greatest single aid to surgical care of tiny infants.

of the anesthesiologist is extremely valuable.

Over the years it has been traditional for the surgeon to have very positive views about the anesthetic agents and technics employed on his patients. Sir Launcelot Barrington-Ward,¹ one of the elder statesmen of pediatric surgery, repeatedly referred to these agents in his writings as "poisons," which indeed they may be. However, in our present enlightened era of anesthesiology it seems only fair to point out that these poisons when intelligently administered become transformed into truly magic potions. Still, what may be highly satisfactory in one set of circumstances may be completely undesirable in another.

The specialty has reached such a level that a dissatisfied surgeon should consider changing anesthesiologists rather than trying to dictate the terms under which an anesthesiologist should work. Any anesthesiologist who is familiar with infants and children and competent in handling them will do a more satisfactory job if he uses the materials and equipment he prefers and understands. I find myself doing less and less surgery under local and regional anesthesia. This might not be so if I were not blessed with highly competent anesthesiologists.

The Subject of Surgery

There is little to be said on the subject of the actual surgery. Presuming the surgeon is competent, or is at least the most skillful operator available, the only admonition I can offer is the Latin inscription from the fly leaf of the book, *Pediatric Surgery*, written by Dr. Edward C. Brenner in 1938.² "In corpore pueri non est locus chirurgiae violentae." For the benefit of some of the young men who were never forced to study Latin, I suppose I should translate—"The body of the youngster is not the place for violent, strenuous, or heroic surgery." However, since no self-respecting surgeon would ever consider his surgery "violentae," I have taken the liberty of modifying the admonition so that it will apply to every surgeon and not just to his competitors: "In corpore pueri non est locus chirurgiae protractae." The shorter the procedure—the less complicated the operation—the better the result will be.

Some very unorthodox surgical procedures have been known to produce highly satisfactory results. In the last analysis, the success of the operation is due to the proper type and amount of preoperative and postoperative care combined with the least surgery that can be expected to preserve life and relieve the condition. Certainly, when the patient's life

is at stake, the emotions of the parents and the economics involved must not be allowed to interfere. The decision to carry out a procedure should be solely on the basis of what is safest for the child. Encores (circumcision, excision of hemangiomas and the like) may sound good to the parents but should never be considered when there is the slightest doubt as to the outcome of the case.

Lifesaving Colostomy

A colostomy or short-term ileostomy may be lifesaving. For the tiny infant, serious thought should be given to establishing a gastric stoma that serves as a vent, and later as a feeding channel. This communication should never be clamped off, as that would defeat its main purpose, which is to prevent aspiration and distention without employing a nasogastric tube.

The use of postoperative care units and recovery rooms has done much for the welfare of the sick infant.³ The concentration of qualified nurses and the more constant observation by anesthesiologists and surgeons of the patients in these units cannot help but ensure a safer postoperative period. Usually this type of transitional care can be of very short duration for small children, and for some of the newborn it may be only a period of reaction from the immediate effects of anesthesia before returning to the specialized nursery care.

Consideration must be given to the differences in the personnel and facilities available routinely, but no rules can be laid down for this aspect of the patient's care. Whether a special postoperative unit is justified is a decision to be shared in by the nursing supervisor and the business office as well as the surgeon and anesthesiologist. Suffice it to say that any hospital which accepts patients in this early age group must assume all the burdens and responsibilities which make this type of service so emotionally gratifying and so economically taxing.

Drainage catheters, suction tubes, oxygen tents, intravenous fluids, and antibiotics all have their part in saving the life of the child. However, the earliest moment at which these can be eliminated safely is the optimal time for discontinuing them, thus cutting down on the complications of infection, possible nursing errors, prolonged immobilization, and undesirable drug reactions.

Formula for Success

Early detection of the surgical emergency, expeditious preparation for surgery, a minimal surgical procedure, all under intensive and intelligent nursing care by dedicated personnel—these constitute the formula for success.

One final word of caution must be added. The physical equilibrium of the tiny infant is subject to sudden rapid change. Continual surveillance is the only way I know to assure a proper basis for diagnosing of a surgical condition, adequately preparing the infant for surgery, and performing the surgery at the right time.

For many years the presence of exhaustive laboratory studies at the clinicopathologic conference has appeared in some way to ease the sense of failure and defeat. How much more desirable for a physician to feel a sense of triumph when dismissing

a patient from the hospital after correct diagnosis, correct preparation, and correct surgical therapy have been achieved with only the essential laboratory studies and necessary physical examinations!

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MYXEDEMA AND COMA

George R. Dillinger, M.D., *Thomasville*

■ ***This condition constitutes a medical emergency of the first order.***

Two illustrative cases are presented.

COMA, IN SEVERE MYXEDEMA, frequently associated with shock and death, has been recognized as a clinical entity. In the past decade, reports of this condition have appeared with increasing frequency.

Several reports appeared in the *British Medical Journal* and *Lancet*, beginning in 1953. Norregaard and Schmith reported two cases in *Acta Medica Scandinavica* in the year 1959. Nickerson, Hill, McNeil, and Barker of Birmingham, Alabama, reported five cases, with one survivor, in May 1960. Other occasional reports appeared in our American literature, until Catz and Russell of Los Angeles, reported 12 cases at the International Goitre Conference, London, England, in 1960. They reported 12 cases with the survival of seven patients. Previous reports indicated that 19 of 25 patients had died.

We wish to report two cases, both of them eventually proving fatal, with the post mortem findings.

Case One — No. 00-99-98

This 56-year-old white female was admitted to the Urological Service of Archbold Hospital on 6-11-55. Complaint: Weakness, mild burning urination. On 6-9-55 she developed a sore throat and nausea. Two days after admission, 6-13-55, a cystoscopy with a retrograde pyelogram was done. A normal urinary tract was reported. On 6-14-55 the patient was seen by a medical consultant. A pale, weak, somnolent, well-nourished, white female was observed. Heart sounds were distant. Coarse rales were present in both lung fields. The face was bloated in appearance. Slight tibial edema was present. The tongue was slick, pale and dry. The gums were spongy and inflamed. Pulse 80—temp. 98—B.P. 120/76. A mild anemia was present—Hemoglobin 11 gms. Urinalysis was normal.

The electrocardiogram showed only extreme low voltage. Chest X-ray—moderate enlargement of the heart in all diameters. Skull X-ray—Lateral film, normal Sella Turcica, no evidence of Pituitary Tumor.

Coma Lapse

The patient lapsed into coma on 6-18-55. The Laboratory reported Cholesterol 306 mg o/o. Protein Bound Iodine 0.7 Mcgms o/o.

On 6-22-55 calcium 8.8 mgs. o/o. Phosphorus 1.9. BUN 12.9. Total Protein 5.2. CO₂ 38 vols. o/o.

At this time she was being treated with Thyroprotein hypodermically (P. D. and Co.); (this drug has since been discontinued). She went into shock on 6-27-55 with B.P. 60/30. Levophed brought the pressure up to normal range. At that time Ca 5.4, CO₂-40 vols. o/o, Potassium 3. Meq/liter and sodium 129.5 Meq/liter. She was started on small doses of Hydrocortisone I.V. and continued on Thyroprotein. On 6-30-55 she was transfused with 500 c.c. of whole blood. Because of some urinary infection, Combiotic and achromycin were given. Good fluid and electrolyte balance were maintained.

With returning consciousness she was started on Thyroid extract by mouth, small doses, 15 mgs. per day, gradually increasing the amount.

She was dismissed from the Hospital on 8-2-55, after 52 days, in good condition. Diagnosis: Myxedema, Adrenal Failure.

Thyroid at Home

Eventually, at home, she was on Thyroid Extract 120 mgs. daily; she did well until her husband had a heart attack in December 1955, at which time she started omitting the Thyroid. She was readmitted to

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the Hospital on November 21, 1960, in an advanced myxedematous state.

ECG—first degree heart block. P. R. Interval .28 seconds, with very low voltage. X-ray—moderate enlargement of the heart in all diameters. A mild anemia was present, hematocrit 34, HB 11 gms. P.B.I. 1.2 mcgms, o/o—Cholesterol 376 mgms o/o. Blood sugar normal. She was started on Thyroid Extract 15 mgs daily and was doing well, when during the night of 11-25-60 she developed nausea, vomiting, and involuntary stools. The blood pressure dropped to 80/60. 500 cc whole blood transfusion was given and the blood pressure was controlled by Aramine. Hydrocortisone was started. At 1:00 P.M. on 11-26-60 the blood pressure was unobtainable and Levophed with 5 o/o Glucose in Saline and 80 meq. of Potassium Chloride was added. She did not respond to therapy and died 6:40 A.M. 11-27-60.

Post Mortem Examination

The Thyroid gland is grossly quite small, weighing 5 gm; it is flabby in consistency. Microscopically—the Parenchymatous elements are replaced by fibrous connective tissue. The persisting lobules have considerable fibrous tissue between the Acini in many areas. The residual lobules are partially infiltrated with lymphocytes and there are often germinal centers present. The follicles are small.

The Adrenals are quite small, each weighing an estimated two grams. The cortices contain a small amount of lipoid. Microscopically the adrenals are extremely thin with diminution of all strata. There are focal areas in the outer strata in which the cytoplasm of the cells is more vacuolated (and more coarsely so) than in the remainder of the cortex.

Pituitary—Gross fixed weight 0.5 gm, quite small and estimated one-fourth usual weight. It is quite flattened. The infundibulum is not unusual in size or location.

Microscopic: The posterior lobe of the pituitary is not remarkable: the anterior lobe is diminished to about one-sixth of the anticipated size. The capsular relationships are not disturbed. There is no interstitial fibrosis in the remaining portions of the anterior lobe.

Diagnosis: Myxedema with Coma, or possible Simmond's Disease.

Case Two — No. 01-16-67

This 63-year-old white female was admitted to Archbold Hospital 9-9-55, to the Medical Service. She complained of severe weakness, nausea and vomiting, occipital headaches and pain in both shoulders and the cervical region.

The onset of illness dated back three years, with increasing weakness and lassitude. The severe head-

aches with some associated nausea and vomiting was of two months duration.

The family history was non-contributory. The past history revealed pneumonia, influenza, rheumatism, and pleurisy, and a cerebral accident in 1951, with a residual ptosis of left upper eyelid.

Examination—Temp. 97.2, P. 70—B. P. 160/95. Well-developed and well-nourished. The skin was pale, dry, scaly, and had a shiny appearance. The hair was very dry, coarse; eyebrows and pubic hair very scant. Excoriations were present at the corners of the mouth. Eyes—ptosis of left upper lid present. Pupils normal. Optic disks normal. Early sclerotic changes in retinal arterioles.

The heart sounds were normal, no enlargement. Lung fields were clear. The abdomen revealed no tenderness or masses. Extremities revealed mild edema and thickening of the skin. The reflexes were reported as physiological.

X-ray of chest—normal heart and aorta. Considerable fibrosis and thickening of the pleura in the right apex. The K.U.B. revealed normal renal shadows and a normal gas pattern in the intestinal tract. X-ray of cervical spine showed marked hypertrophic arthritis in the lower cervical spine. The E.C.G. showed very low voltage, otherwise normal.

Cholesterol 504 mgms. o/o. Fasting blood sugar and B.U.N. were normal. Blood count revealed a mild anemia, hemoglobin 11.5 gms. Urine—Trace albumin; otherwise normal. Protein bound iodine 1.5 mcgms o/o. B.M.R. reported examination unsatisfactory.

Diagnosis

The patient was diagnosed as Myxedema, and possible vitamin B deficiency. She was treated with U.S.P. Thyroid Extract, starting with 15 mgs. daily. She was also given vitamin B and C complex orally. She improved dramatically and was discharged on September 14, 1955. Diagnosis: Myxedema—osteoarthritis cervical spine.

The patient was seen at an office visit two weeks after discharge. She was much improved and complained only of occasional nausea. The thyroid extract was increased to 30 mgs. daily at this visit.

On 10-29-55, about six weeks later, she was readmitted to the hospital, complaining of severe nausea and vomiting of 14 days duration. She also complained of shortness of breath and pain in the knees.

On admission P. 88 irregular, T. 98.0; B.P. 130/-70. Skin pale, dry and rough. Heart sounds normal. Tender, painful knees. The E.C.G. showed low voltage with frequent premature systoles. Urine—Sp.G. 1.012 Albumin 1÷, few hyaline casts. Blood picture unchanged except elevation of W.B.C. 11,100. Sedimentation rate 46 mm per hour, P.B.I. 3.2 micro-

grams o/o. CO₂-40 vols. o/o, BUN-normal. On 10-30 the patient complained of more pain in the knees and was increasingly more lethargic. She was taking very little food and was being given I.V. glucose and saline. On 10-31-55 Thorazine 25 mg. q.i.d. was started for nausea and vomiting. On 11-1-55 she lapsed into deep coma with no perceptible blood pressure. She was given Wyamine 15 mg. subcutaneously. Within 30 minutes the blood pressure was 30/0 and she was started on Levophed in 5 o/o glucose infusion. 100 mgs. of hydrocortisone was given I.V.

At 10:20 A.M. the serum potassium was reported as 1.3 Meq/liter and sodium 130 Meq/liter. 80 meq. of potassium chloride was added to the Levophed Glucose Solution. Adequate blood pressure was maintained until 1:30 A.M., 11-2-55, when it dropped to 60 systolic. The patient failed to respond and died at 4:20 A.M.

Diagnosis: Myxedema with adrenal failure.

Post Mortem, Case Two

Thyroid Gland—It is extremely small, each lateral lobe being only a narrow band of firm gray tissue. Microscopically—there were several well-developed vesicles. These are filled with pale colloid and lined by cuboidal epithelial cells in single layer. There is a marked increased amount of interstitial connective tissue. In the matrix there are a few discrete lymphoid cells.

Adrenal Glands—Weight about 5 gm.; the cortices narrow, and the medullary portions scanty. Microscopic—the amount of medullary tissue is small, the existing cells appear normal; they are enclosed in part in mature non-fibrotic vascularized connective tissue. The three zones of the cortex are intact, normal in position and sharply defined.

The head was not opened.

Diagnosis: Myxedema and coma. Adrenal failure.

These two cases well illustrate the problem of Myxedema with coma. Both cases were very severe and prolonged. They both responded to initial treatment. Case Number One, after prolonged coma, recovered and remained in reasonably good health on thyroid extract five years. We believe that the cystoscopy and urinary infection precipitated the coma. On stopping medication, the Myxedema recurred, after several months. Nausea and vomiting developed and she eventually deteriorated into coma, electrolyte imbalance and death in shock. Coma may have been precipitated by sodium pentobarbital.

The second case was apparently on the road to recovery, when she developed nausea and vomiting, which persisted. She lapsed into coma, shock, elec-

trolyte imbalance and death, probably precipitated by thorazine.

The gross and microscopic changes in the thyroids and adrenals of the two patients were similar.

In the one patient, we were permitted to open the skull and found the anterior lobe of the pituitary to be diminished in size, but the cells were normal. However, there was not the fibrosis and destruction usually seen in Simmond's Disease, nor was cachexia present in either patient.

Comment

The nausea, vomiting, anorexia, prostration and hypotension are characteristic of adrenal shock. Loss of thyroid function predisposes to adrenal incompetence.

Myxedema with coma is a specific clinical entity. It probably occurs much more frequently than it is reported.

Circulating thyroid hormone is necessary to potentiate the action of the Vasopressors.

Adrenal steroids are also necessary for the proper action of the Catecholamines.

It has been suggested that in Myxedema, the adrenal gland is working at a hibernating pace and is able to maintain a Myxedema metabolic state. The Myxedematous adrenal is unable to cope with stress because of the decreased utilization of the circulating steroids. Therefore, adrenal insufficiency occurs, in the stressful situations such as infection, surgery, anesthesia, injury or the administration of certain drugs. Both barbiturates and Thorazine have been reported as precipitating coma. Death is due to peripheral vascular collapse.

At the present time, the management of Myxedema with coma depends on early recognition of the clinical condition and prompt and vigorous treatment. It is a medical emergency of the first order. Immediate control of electrolytes is mandatory, the judicious use of small doses Thyroid Extract 15 mgs. daily, or 12.5 msgms. of Triiodothyronine b.i.d., and Hydrocortisone 50 mgs. or its equivalent, q 6 h is required.

Successful management of this condition depends on the awareness of its existence, by the physician. Treatment must be started without waiting for chemical confirmation.

Summary

The clinical entity Myxedema with coma is discussed.

Two cases that at first responded to therapy for Myxedema are presented. Both later died in coma and shock. Electrolyte imbalance, with low potassium, calcium, and diminished CO₂ combining power was present.

Post mortem findings of the thyroids and adrenals

were almost identical in the two cases presented.

Prompt treatment of any infection by antibiotics is necessary. The control of electrolyte imbalance, administration of Thyroid Extract or Triiodothyronine, adrenal steroids, and vasopressors are essential in the management of this disease state.

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How well are we telling our story to the people of Georgia? Judging from the number of stars on the accompanying map, not so well. These stars pinpoint locations where physicians have sought to enhance the image of the profession through the medium of public speaking to lay groups on both medical and non-medical subjects.

Most everyone agrees that we must have public support for policy positions taken by the profession, if those positions are to prevail over the long pull. The sad truth is that during the months of November and December only 12 public addresses by physicians were made and reported. Were this figure 112 it might be laudable, but even this seems small when measured against the consequences of our failure to mobilize public opinion.

Such Lilliputian efforts are not equal to the problem. We must quadruple our efforts to inform the public or be prepared to stand alone against those who have professionalized the art of downgrading the free practice of medicine.

County Society Secretaries are urged to report all public speaking engagements by members of their society. Post cards addressed to the *Journal* have been provided for this purpose.

How well are we telling our story?



SELECTION OF AGENTS AND TECHNIQUES IN ANESTHESIA

Paul W. Searles, M.D.,* *Chicago, Illinois*

- ***Perhaps the best anesthetic in the face of a poor risk patient is that which one has learned to use and know.***

BEHIND THE CHOICE OF AN ANESTHETIC is always a thought and a search for the ideal anesthetic. As Proust said, "Medicine is not an exact science and just as each man's world is an influence made from what his senses have perceived, so each anesthetist's opinion of a technique is a conclusion drawn from what he has known it to do."¹⁷ Although the *ideal anesthetic* has not been found, it is significant that this has been attained by the combination of agents and taking advantage of their best attributes.

Surgeons differ markedly in their requirements and no hard and fast rules can be made. Each anesthesiologist has learned by trial, deduction, and study the agents and methods which, in his hands, are best for his patient's safety and for the surgeon with whom he works. Nevertheless, the final choice of the anesthetic may be considered from three different angles, namely the status of the patient, inherent property of the principal agent and the important considerations of the supplementary agent or method.

Status of the Patient

Very Old Patients

It is the variety of degenerative diseases which accompanies old age that may constitute the hazard. These are arteriosclerosis, heart disease and a general weakening of functional capacity of vital organs. Although many would agree with Grosskreutz that cyclopropane is the most desirable agent for the geriatric patient, other agents may be used safely if it is borne in mind that only minimal amounts may be

required; with good judgment waiting in every case for an adequate length of time for the full effect of the drug before another dose is given.¹⁰ Although some authors list subarachnoid block as being unwise in the elderly, it is used quite successfully in a number of urological and lower extremity procedures. It is the ability to control the desired low level of spinal analgesia and the prompt corrective measures that overcome possible hypotension that make the technic acceptable in the hands of those well trained.

Very Young Patients

Pediatric limitations in the choice of anesthesia arise out of the fact that they may be unable to cooperate with the surgeon and the anesthesiologist, and also because their size limits their capacity to resist shock, hypoxia and particularly obstruction of the airway. It must be remembered that because of the abundance of loose connective tissue in the larynx of the child and the relative narrowing of the subglottic region, laryngeal complications may follow after intubation.²² The agent selected is not nearly so important as is the adequate preparation of the patient which would preferably include a preoperative visit with the parents.

Hypoadrenocortical State

This may be brought about by disease (Addison's) or taking of steroids. In either case preoperative administration of the hormone is necessary because the possibility of sudden circulatory collapse is ever present. Stress particularly associated with surgery may be catastrophic in patients whose adrenal cortex is unresponsive as a result of previous hormonal treatment. Ether is particularly contraindicated.¹ The

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deficiency of sympathetic nervous system mechanisms makes the use of subarachnoid block unwise. Of the available agents the least of the adrenergic agents, like fluothane and nitrous oxide are tolerated well.

Hyperadrenocortical State

Phaeochromocytoma exemplifies this condition and because of the increased adrenalin released from the disease the agents that may be employed are those with the least chance of aggravating this condition as well as those that will not provoke increased cardiac irritability in the presence of adrenalin. A smooth induction is mandatory as well as the use of ether, and nitrous oxide and intravenous demerol.

Carcinoid

The release of serotonin and the subsequent effects like profound hypotension and severe bronchial constriction probably make this case one of the most difficult to put under anesthesia. Palpation alone may release serotonin while hypotension is said to provoke the release even more so.²⁵ As you may deduce, vasoconstrictive agents like cyclopropane are contraindicated. Nitrous oxide-ether sequence is recommended.

Debility

Patients whose general condition is poor tolerate all anesthesia badly but can usually be well managed if the dosage of the agent is kept appropriately small. These persons are particularly sensitive to the barbiturates. Therefore, pentothal sodium should be used with great caution. Spinal anesthesia is not a wise choice. Most satisfactory is a combination of agents and methods, such as regional anesthesia combined with the administration of a nitrous oxide and oxygen-rich mixture. Halothane may be added to this combination to permit less nitrous oxide and more oxygen to be employed. Adequate ventilation at all times is of paramount importance.

Shock

Adequate fluid replacement evidenced by attainment of recognizable clinical state compatible with survival is the first line of management before any thought of anesthesia should be considered. Local anesthesia may be the safest.

Because of the low blood volume, a technic that will insure adequate oxygenation should be employed. Anesthesia should be as short and as light as possible. In this connection hypotension, being the most important signs to be prevented, should bear careful watching.

For patients in shock the cautious use of small doses of thiopental sodium to produce sleep in conjunction with 50 per cent of nitrous oxide-oxygen and small doses of a short acting muscle relaxant

administered by intermittent intravenous drip is recommended. Intratracheal technique is resorted to as soon as relaxation is obtained and respiration assisted throughout the operation.¹⁶

Likewise, it has been experienced that patients taking hypotensive drugs for their hypertension may go into shock under anesthesia. This has particularly been associated with some of the tranquilizers and rawolfia drugs. It is advised that patients on this kind of therapy should be weaned from these drugs for at least two weeks before undergoing anesthesia.

Fever

There are times when surgery is mandatory in patients with high temperatures and they should be given the highest possible concentration of oxygen and every effort should be made to reduce the body temperature. Among the simplest ways are the omission of belladonna drugs in the preoperative medication, the use of promethazine, the employment of semi-open or semi-closed circuit; adequate hydration and the generous use of "alcohol sponge" before and following induction.

Obesity

Obesity alone demands caution in the choice of agent and method but does not present positive contraindication to any method. Some of the inhalation agents, notably ether, must be administered for longer periods and frequently excessive concentrations are required to achieve the desired result. Often the airway is difficult and superficial veins are hard to find before induction. Spinal anesthesia may be undesirable in the presence of great obesity.

Pregnancy

Due consideration should be given to patients in pregnancy. Special problems related to toxemia of pregnancy may be present; for example, use of hypotensive agents, and diuretics. It has been our experience that some of the near term patients may go into hypotensive episode while supine due to pressure of the large uterus on the large vessels like the inferior vena cava thus obstructing venous return flow to the heart. In this particular case, prevention may be made by turning the patient on her side.

Hypersensitivity: Locals

The local anesthetics are among the most common cause of hypersensitivity. A careful history will usually bring out this sensitivity. No local anesthetic should ever be administered without proper means of resuscitation such as an intravenous barbiturate, oxygen, and adequate means for establishing an airway.

Hypersensitivity: Barbiturates

Patients with porphyrin disease are extremely sensitive to barbiturates. The existence of porphyria

absolutely contraindicates the use of barbiturate anesthesia as lower motor neuron paralysis and death may ensue.²⁶

Hypersensitivity: Muscle Relaxants

The newborn is extremely sensitive to non-depolarizing relaxants. The depolarizing type is the muscle relaxant of preference for infants.²¹

The curare drugs are contraindicated in myasthenia gravis. Ether is not a preferred choice because of its curare-like action.

In those patients with low cholinesterase levels (liver disease, etc.) as well as low serum potassium (after the use of certain diuretics), a depolarizing relaxant is a poor choice.

Arthritis

The presence of calific deposits often make spinal subarachnoid anesthesia difficult. Ankylosis of the cervical vertebrae and the jaw prevents adequate extension of the head and opening of the mouth, in both instances making intubation not easy, not to mention a bad airway. In such an instance, an airway must be established by passing an intratracheal tube with the patient awake or by performing a tracheotomy.

Anemia

In marked anemia, cyanosis should not be depended upon as a sign of hypoxia. This condition, limiting as it does the oxygen-carrying capacity of the blood, requires that the choice provide adequate oxygenation and ventilation. One induction injection of thiopental sodium should be sufficient, otherwise prolonged cumulative effect would reduce the number of circulating red blood cells by causing their absorption by the spleen.²⁰

Administration of ether by the semiopen drop method should be avoided unless oxygen, nitrous oxide, or ethylene and oxygen are added in strengths that permit oxygen concentrations of at least 40 per cent. Spinal anesthesia is likewise dangerous because of the strong possibility of impairing peripheral circulation and the more remote possibility of respiratory depression. Further, it is inadvisable to use spinal anesthesia when pernicious anemia may be present because of the involvement of the spinal cord by the primary disease. Cyclopropane is most satisfactory in these cases.

Cardio-respiratory Disease

In the asthmatic patient, cyclopropane should be avoided because it can be a potent bronchiolar constrictor if a reflex such as coughing or straining is allowed to develop. Thiopental sodium may be used with great caution and in small dilute quantities for

induction purposes, despite its mild bronchiolar constricting property. Demerol given intravenously to supplement nitrous oxide-oxygen is one of the well-chosen sequences. Ether is still one of the best agents in the asthmatic, although the advent of fluothane has relegated it somewhat to the background. The choice of relaxants fall on the synthetically made rather than on the naturally occurring alkaloids because of the minimal tendency to cause histamine release.⁹ The presence of an intratracheal tube may provoke an asthmatic attack.

Similar Choice

The choice of the anesthetic in the emphysematous patient is not much different from that of the asthmatic. Nevertheless it should be borne in mind that it is the effective alveolar ventilation that really counts and more often than not, even without anesthesia, the emphysematous patient breathes with a slow rate of about 12 respirations per minute with a prolonged expiratory phase. Therefore, this sequence of breathing should be simulated as much as possible allowing great effort for expiration if respiration is controlled. An assisted respiration is recommended in as much as in this manner the chance of rupturing emphysematous bullae would be less.

Coronary artery disease contraindicates the use of cyclopropane because it may aggravate the already impaired myocardial circulation. Oxygen administered preoperatively and during induction is always recommended. Anesthesia is bound to be hectic and dangerous during the first three months following a myocardial infarction. Likewise, the presence of congestive heart failure will complicate the choice. The successful administration of anesthesia to a patient with heart disease depends on adequate preoperative sedation, a smooth induction, and the avoidance of sudden circulatory changes by the use of combined light anesthesia.¹⁹ Success does not depend on the magic cardiogenic properties of a particular agent.

Intestinal Obstruction

Obviously a spinal anesthetic should be contraindicated in any severe type of intestinal obstruction because of increased parasympathetic tone which can provoke more spasm and even rupture of a viscus. Relief of distension assisted by gastrointestinal drainage to prevent aspiration should be done first before any attempt at topical intubation is made followed by administration of a general anesthetic. Safety can be assured patients with intestinal obstruction only with a cuffed endotracheal tube inserted under topical anesthesia with the patient conscious. The intratracheal tube should not be removed postoperatively in these cases until the patient is fully awake and able to control his own reflexes.

Hepatic Disease

The important consideration in cases of liver disease is avoidance of agents that produce adverse changes in the chemical constituents of the blood or depress peripheral circulation or may be detoxified in the liver. As a general rule, narcotics are poorly tolerated. Chloroform, avertin, ethyl chloride, and vinyl ether should not be used in the presence of marked disease of the liver. The use of ether is questionable and should depend on whether or not adequate oxygenation can be maintained, and whether or not a great depth of anesthesia is necessary. Detoxification of local analgesic drugs occurs in the liver, and speed of destruction is a measure of their toxicity. Liver disease may therefore increase the toxicity of these drugs. Commonly used inhalation agents such as cyclopropane and nitrous oxide may be used safely if the plane of anesthesia is kept light. A small induction dose of pentothal sodium can be tolerated even in the presence of jaundice. Curare may be used as needed. According to Dundee and Gray, patients with liver disease may actually show a resistance to the relaxation properties of curare.⁵

A host of other diseases may limit the choice of the anesthetic agent and technique. Familiarity with all the limitations is a measure of the anesthesiologist's ability.

The Inherent Property of the Principal Anesthetic Agent

Cyclopropane

For the past 25 years, cyclopropane has been the "work horse" of anesthesia, its popularity deriving from its superiority to ether in the matter of quick induction and quick emergence. Its harmful attributes are mostly due to overdosage, not to mention improper respiratory control. Its inflammability, high cost when used in anything but closed systems, incompatibility with epinephrine, and occasionally its bronchospastic and vasospastic properties limits its application.

Nitrous Oxide

Nitrous oxide has been called our most nearly perfect anesthetic agent and except for the fact, when used in safe combination with oxygen it lacks the potency required for most general surgery, it well deserves the acclaim. For short procedures, requiring only analgesia, it is difficult to conceive of any inhalation agent which presents more advantages and fewer disadvantages than nitrous oxide. It provides a quick not unpleasant induction. It is totally non-irritating to the respiratory tract and has no direct adverse effect on either circulation or respiration. Recovery is quick and complete.

Fluothane

In recent years perhaps there has not been one agent that has received almost meteoric prominence as fluothane. It is non-inflammable, potent, non-irritating and pleasant. The introduction of precision equipment to control the concentrations administered during anesthesia has made this and similarly potent agents, almost a pleasure to administer. The associated hypotension which often follows after induction with a barbiturate is potentiated by the administration of fluothane. As with any potent agent of this nature, even relative hypoxia aggravates the hypotension which invariably occurs when stimulation of any sort is done to the patient (moving the extremity, scrubbing, shaving, incising, etc.). Fortunately the sudden cardiovascular collapse and delayed hepatic damage are not associated with this agent when used properly and particularly with adequate oxygenation.²⁴ As with any halogenated anesthetic, its toxicity increases with the number of halogen atoms. The use with epinephrine is unwise.

Chloroform

There is little question that chloroform used as an anesthetic provides nearly ideal conditions for most surgical procedures. It is potent, non-irritating, pleasant and is non-inflammable. Nevertheless, it has a very narrow margin of safety. It is contraindicated in liver disease as well as in the presence of epinephrine.

Diethyl Ether

Frequently termed the "standard" anesthetic because of its wide application, its wide margin of safety, and its great versatility, it has been given orally, by rectum, intravenously, and by inhalation with every conceivable type of apparatus. It enjoys the esteem of uncounted physicians, surgeons, and both the "occasional" and the well-trained anesthesiologist. It is detested by many patients. The dosage required for surgical anesthesia and its own physical characteristics render this agent difficult to administer in overdose by the open mask technique, when the airway is kept patent and the oxygen is added under the mask. When ether is administered through the agency of one of the modern anesthesia machines, by closed or semiclosed system with carbon dioxide absorption, and with some form of endotracheal airway as indicated, there are few surgical procedures that cannot be accomplished satisfactorily. Its potency measured in terms of the muscular relaxation provided is comparable to that of chloroform and is certainly greater than that of the other commonly used inhalation agents.

One principal contraindication of the use of ether lies in the fact that it is flammable, and within wide range of dilution in oxygen, is highly explosive.¹³

Another less serious, but more commonly encountered disadvantage to the use of ether, lies in the period of malaise with occasional excessive nausea and vomiting following the use of this agent. Ether vapor is irritating to the respiratory tract and this fact may be deemed important enough in some circumstances to contraindicate its use. Its use is also known to be accompanied by marked alterations in the chemical constituents of the blood, such as elevation of blood sugar, reduction of the CO₂ combining power, and elevation of the non-protein nitrogen of the blood, which would render the choice of this agent inadvisable for some patients.

Divinyl Ether

"Vinethene," its more popular trade name in recent years, has been relegated to the role of an induction agent. It is still an excellent agent for adults for short procedures such as the incision and drainage of an abscess, removal of sutures, and the insertion and removal of surgical packs. Divinyl ether is a pleasant, quick-acting anesthetic which is characterized by rapid recovery with few side effects other than salivation. The agent is, unfortunately, highly flammable, produces little muscular relaxation, and is hepatotoxic when used for periods of time required by most surgeons.

Fluoromar

Fluoromar, the trade name for trifluoethyl vinyl ether, resembles ether more than chloroform in its action. Although claimed to be not flammable in the usual clinical ranges employed, its use in the presence of cautery is a hazard and not recommended. It is not irritating to the respiratory tract and can be used in the presence of epinephrine.

Pentrane (methoxyfluorane)

Pentrane, the newest of the fluorinated ethers, has a smooth induction period because it is non-irritating, but slow because of its high boiling point and consequent poor vaporizing. Respiratory and cardiovascular depression are comparable to that of halothane with a striking muscular relaxation profoundly better than that of ethyl ether. Recovery is slow compared to that after ethyl ether. The incidence of nausea and vomiting is midway between that of ethyl ether and halothane. Liver dysfunction is no greater than that seen with ether or halothane.¹¹

Trichlorethylene

Trichlorethylene resembles chloroform in its formula, its odor, its freedom from irritant effects and its nonflammability. It differs from chloroform in that little muscular relaxation is produced and it is not as hepatotoxic and depressant to the myocardi-

um. An excellent analgesic agent, its main disadvantages are the occurrence of tachypnea, bronchial constriction and often convulsion as well as the contraindication with the use of soda lime. Even after its use a patient may not have a carbon dioxide absorption type of anesthetic for a few days without the danger of its decomposition products.⁴

Ethylene

An analgesic of the order of nitrous oxide, ethylene has served well the obstetrical field in many places. Its rather pungent odor may be abhorred by some, but its main disadvantage is its flammability. Occasionally a patient who has difficulty going to sleep under nitrous oxide may have the advantage of this gas.

Important Considerations of the Supplementary Agent or Method

Intravenous Agents: Barbiturates

While a great number of barbiturates have been administered for the purpose of providing surgical anesthesia, only the ultra-short acting members of this large group of drugs have been found practical in this regard. Always to be considered as a sedative, and never an analgesic, thiopental sodium is the best representative of this group and has by far enjoyed the widest and almost pampered popularity. Nevertheless an excellent drug in its own right, the following facts must be kept in mind; thiopental sodium is a powerful agent, when rapidly administered even in small doses, it is a potent respiratory depressant, the effect of a single large dose rapidly injected may be difficult to reverse, and individual tolerance is most variable and varies with the physical condition.¹²

The trend today is to use thiopental sodium in a "sleep dose" for induction since the amount required for full anesthesia places severe strains on the cardiorespiratory systems.

Extremes of age once considered to be contraindications to the use of thiopental sodium are now only relative contraindications. Shock and debility also fall into this same category. With the exercise of great care in judging the dosage (most amazingly small doses suffice) and with care in insuring the oxygen needs of the patient, anesthesia can be induced in the majority of surgical patients with intravenous anesthetic agents.

Intravenous Agents: Muscle Relaxants

Muscle-relaxing drugs have vastly increased the field from which anesthetic agents and methods may be selected. Thus, the anesthesia chosen can be adapted much more closely to the particular needs of the patient. The dangers associated with the use of relaxants are chiefly those associated with decreased pulmonary ventilation, a condition which the anesthesiologist can correct. The relaxants should

always be employed in a manner which makes them a supplement to good anesthesia rather than a mask for bad anesthesia.

For a time it appeared as if there were clear-cut advantages associated with a nondepolarizing agent, such as a curare compound, over the depolarizing agents, such as the short-acting suxamethonium compounds, because of the existence of specific antidotes for the former. Conversely, the ultrashort duration of action of the succinic acid esters manifestly made these agents superior for procedures requiring rapid onset of profound relaxation but for periods of short duration. The depolarizing compounds have other advantages in that they seemingly do not cause the release of histamine and are not ganglionic blockers. The difficulties in distinguishing the superiority of one type of drug over the other appeared when anesthesiologists began giving the two drugs to the same patient in varying degrees of sequence and with varying degrees of success.

Distinctive Drug Introduced

Recently a third and distinct type of curarimimetic drug has been introduced. One such drug, hexafluorenum bromide, is a very efficient plasma cholinesterase inhibitor, and is used in conjunction with succinylcholine to minimize the dose and extend the duration of the latter. Hexafluorenum compounds in essence convert the short-acting succinylcholine into a long-acting agent without risking the hypotension and bronchospasm occasionally seen after the use of the curariform drugs.⁷ As an additional bonus, the hexafluorenum compounds prevent the muscular fasciculations caused by succinylcholine and thereby decrease the incidence and degree of muscular pain seen after the use of succinylcholine.

Intravenous Agents: Narcotics

Intravenously administered drugs like demerol, morphine, and its related compounds have found favorable use in anesthesiology as supplements to weak inhalation agents like nitrous oxide to provide a more stable and continuing analgesia. If given with careful judgment and small serial injections, depression of vital signs may not occur. These drugs are prone to depress the respiration when given, and it becomes a necessity to support the respiration with constant watchfulness. The prolonged postoperative analgesia with adequate laryngeal suppression for easy extubation are among its best attributes.

Intravenous Agents: Procaine and Other Local Anesthetics

Intravenous procaine as a supplement to other forms of anesthesia has been used for many years with cycles of enthusiasm followed by times of disfavor.² It is often used in thoracic and cardiac surgery as a

continuous intravenous infusion with the thought of reducing the irritability of the automatic conductive tissue of the heart, in this respect quinidine-like. One-half of one per cent solutions have been used to alleviate broncho-spasm, serum sickness and status asthmaticus; to produce analgesia in the dressing of burns; to relieve pain in vascular spasm and insufficiency; and to relieve intractable pruritus.

Intravenous xylocaine is experiencing some rise in popularity today. Besides its apparent better degree of analgesia and suppression of laryngeal reflexes, it has the happy effect of producing somnolence.²³

The use of local anesthetic agents intravenously should be avoided when succinylcholine is being used as a muscle relaxant because of their competitive effect on the plasma pseudocholinesterase.

Rectal Agents

Rectal tribromethanol (Avertin), and thiopental sodium have been relegated to pediatric anesthesia for basal narcosis and rather minor surgical procedures like cardiac catheterization, angiography, cystoscopy and eye examination.

The rectal route for the administration of anesthetic agents has the unavoidable disadvantage of lack of control of the dose due to inconstant absorption and technical difficulties of replacing inadvertently lost drug. Besides this, the need of preparing freshly made solutions each time to prevent tonic decomposition of the drug makes it cumbersome. It is needless to say, that as in any other forms of anesthesia, respiratory depression constitutes another hazard.

Hypothermia

The development of hypothermic technics in conjunction with other advances in anesthesiology has permitted the introduction of radical law technics in cardiovascular and neurological surgery.¹⁸ Many previous factors about hypothermia are being resolved. I am sure most of you know all the different ways of producing hypothermia, some of its biological effects, its advantages and many of its disadvantages and will often pause to ask what are the salient features in hypothermic anesthesia.

Blair classifies hypothermia according to the degree of functional alteration: *Augmented hypothermia* includes subnormal temperatures down to 33°C, *Moderate* down to 30°C, *Moderate deep* down to 25°C, *Deep* down to 20°C, and *Severe* below 15°C.³

Essentially there are two ways of lowering the body temperature, namely surface contact and blood stream cooling.

Surface contact is used for more moderate and prolonged periods of clinical cooling (33°C to 28°C), using ice water bath immersion, ice bags, cold air circulation, refrigeration blankets, as well as alcohol evaporation.

Evaporation hypothermia, using alcohol sprayed on the body has been used and recommended especially for older patients (60-85 years). No metabolic acidosis, good peripheral vascular dilatation and the difference between the skin and rectal temperature is maintained although shifted to lower temperatures (Normal= $32^{\circ}\text{C}/37^{\circ}\text{C}$ to $25^{\circ}\text{C}/30^{\circ}\text{C}$).

Disadvantage of Surface Cooling

One big disadvantage of surface cooling is the considerable drift in temperature ("after-fall" on cooling and "overshoot" on rewarming), so that allowance of about 2°C should be made. The drift is thought to be due to attempted equilibration between superficial and deep core temperature toward the normal gradient of 2°C . It is probably partly due to reduced heat production and blocking of temperature regulation. Upon rewarming, the superficial vessels dilate, pooling blood in the periphery and increasing surface tissue metabolic demands, while the heart is still cold and moving blood at the corresponding slow rate. A shock-like state may develop as well as metabolic acidosis. So that, an approach to the management of this problem is to allow the patient to rewarm at his own rate.

Blood stream cooling and rewarming by means of the heat exchanger is more rapid, efficient and controllable than is surface cooling. However, disadvantages lie in the complexity of the equipment, intravascular cannulation with potential hazards of thrombosis, infection, bleeding and the need for constant supervision of well-trained personnel.

Whatever the method of cooling the patient, it is generally accepted that hypothermia alone decreases the platelets, decreasing coagulation. It also decreases the pH and thus the need for hyperventilation to prevent increased cardiac irritability prone to occur at about 28°C . Respiration ceases at 30°C to 24°C . There is a decrease in the dissociation of oxygen with a consequent increase oxygen dissolved in the plasma and a shift of oxygen dissociation curve to the left.

Perhaps the most important aspect of hypothermia is its close similarity to the state of hibernation with almost complete analgesia at about 35.5°C .¹⁵ This is significant in that minimal anesthetic drug is necessary after this temperature is reached.

Various drugs which antagonize acetylcholine could produce mild degrees of hypothermia. Among this group of drugs are chlorpromazine, demerol, atropine, benadryl, procaine and quinadine. The muscle relaxants have their place in increasing the cooling rate by preventing the occurrence of shivering which increases oxygen consumption 200 to 400

times.¹⁴ However, precautions should be taken in the rewarming period that adequate ventilation be maintained as some residual relaxant effect may be manifest.

Summary

Familiarity with all the limitations is a measure of the anesthesiologist's ability. But then the limits are variable and today's armamentarium of the anesthesiologist provides a wide range of choice and only experience will dictate and prevent the pitfalls of a previous shortcoming. Perhaps the best anesthetic in the face of a poor risk patient is that which one has learned to use and know. Frequently, deteriorating vital signs may be resuscitated by a shift to another agent. It is a great source of satisfaction to the anesthesiologist to see his patient wake and be able to respond to his surgeon shortly after the last stitch is placed. The depth of anesthesia should be adjusted to the actual needs at any moment. Magill once said that the "depth of anesthesia is too great when the anesthetist winks at the patient and the patient does not wink back." It would provide us with more excitement and greater personal satisfaction, "to navigate the patient through the operation without wallowing in the deep sea of anesthesia, but rather, to skim across the waves of analgesia."

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CURRENT ROLE OF HYPNOSIS IN MEDICINE

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■ **An estimated six to seven thousand physicians and an equal number of dentists are utilizing hypnosis in their practices.**

WHAT, IF ANY PLACE, does hypnosis have in the practice of medicine? Is it a fit subject for serious study and research by physicians, or is it just a tool for parlor entertainment or the nightclub stage? What are its limitations and dangers? How can the interested doctor learn to employ it effectively with his patients?

The medical profession's usage of the phenomenon known as hypnosis has been characterized by tidal waves of interest, followed by ebbing apathy and even outright hostility. At the present time we are witnessing a strong resurgence in the use of this ancient technique. Indeed, one can safely say that a new high water mark has been reached in the profession's interest in hypnosis; there is every indication that the future will evoke an even more widespread usage of this potent therapeutic and investigative tool.

Increasing Use For Hypnosis

To what factors do we owe the present interest in hypnosis, and why is it likely that the medical profession will find increasing use for hypnosis in the future? Hypnosis has always been surrounded by an aura of magic, so it is not surprising that in times of crises, when men yearn for a quick, miraculous remedy for their woes, hypnosis comes to the fore. In psychiatric terms, the ego surrenders certain of its executive functions to a powerful external force, the hypnotist. When there is acute catastrophic stress such as is seen in combat and air raids in wartime and accidents during peacetime, the resultant emotional states are often dramatically alterable by hypnosis. For example,⁵ during the acute phases of the

Okinawan campaign of World War II, hypnotizability of patients with combat reaction was almost 100 per cent, there being only seven failures in 2,500 patients, even though only one of the five psychiatrists who participated in this work had had previous experience with hypnosis. However, as time in combat increased, and the situation became more chronic, the hypnotizability rate decreased markedly.

The exigencies of the Second World War brought forth many serious emotional problems. Attempts to deal with these difficulties involved many approaches and stimulated the interest of numerous physicians in psychiatry. This situation sparked the postwar growth of modern, dynamic psychiatry, as well as the growth of hypnosis.

In contradistinction to the periodic swings of the past in the use of hypnosis, today both the profession and laity are far more sophisticated and knowledgeable about this phenomenon, which is a corollary of the widespread concern with all phases of man's psychological functioning. There has been a spate of popular articles on the topic, while two television programs produced under the supervision of medical schools³ have been shown to nation-wide audiences. On the professional side, new books appear almost monthly. Two journals devoted to hypnosis are published quarterly. (*American Journal of Clinical Hypnosis* and the *International Journal of Clinical & Experimental Hypnosis*). The pages of psychiatric journals virtually bristle with such articles, and even such a venerable publication as the *Journal of the American Medical Association* not infrequently publishes contributions in the field of hypnosis. Two years ago it was estimated that six to seven thousand physicians and an equal number of dentists were utilizing hypnosis in their practices. The

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American Society of Clinical Hypnosis has over 2,000 members recruited from the ranks of physicians, dentists and psychologists.

Many of the publications, moreover, represent solid research and sober thought. An extensive monograph by Gill and Brenman⁴ is based upon fifteen years of intensive research and clinical application of hypnosis, attempting to explain hypnosis and relate it to other phenomena such as somnambulism, fugues, traumatic neurosis, and brainwashing. Barber¹ has shown that the rate of analgesia produced by hypnosis (approximately 30 per cent) is quite similar to that achieved by the use of placebos. Marmer⁷ reported on the use of hypnosis as an analgesic agent in open heart surgery, including one case in which a mitral commisurotomy was performed without the use of any chemical analgesic agents.

Hypnosis in New Context

The clinical and experimental work previously alluded to has served to place hypnosis more in a rational, scientific context; our increasing knowledge of psychodynamics has made the process more intelligible and less magical.

Perhaps most important, there is growing recognition of the importance of the lighter stages of hypnosis. For example, many workers have noted that in using hypnosis as an adjunct to psychotherapy, there is no correlation between therapeutic results and the depth of the hypnosis. In a study of intractable pain,⁶ patients who achieved a very light hypnoidal state, or who were first thought to be completely refractory to hypnosis, often achieved significant reduction of their pain. Until recently it was felt by many workers that unless a stage of somnambulism was reached, hypnosis could not be an effective tool, and accordingly, many physicians were discouraged inasmuch as only a small percentage of individuals are able to enter into a deep trance.

Relationship

Since this exposition is designed to pinpoint the place of hypnosis in relationship to medicine in the year 1962, with particular reference to opportunities for training in the use of hypnosis; the techniques, phenomenology and application of hypnosis are accordingly mentioned, but in passing. The interested reader is directed to the standard texts for more information on these topics.⁹ However, certain fundamental considerations of the uses of hypnosis in the practice of medicine must be stressed. Primarily, it should be emphasized that hypnosis in itself is not a method of treatment. Used within the framework of a physician's own professional training and competence, hypnosis can be a valuable adjunct. In se-

lected cases, and generally for limited goals, hypnosis can produce striking results. Anesthesiologists or surgeons may produce anesthesia or analgesia without the use of chemicals, for both minor and major surgery. Various kinds of instrumentation can be carried out without discomfort to the patient; babies may be birthed without the depressant effects of anesthesia and analgesia; certain acute psychic problems may be dealt with more promptly, etc. These results are everyday occurrences, without untoward sequela when hypnosis is utilized with problems the physician would ordinarily treat in his own practice. Like other potent therapeutic tools, hypnosis may, if improperly used, produce serious consequences to the patient. There are published examples where the appearance of a florid psychosis has resulted from the removal of seemingly mild psychiatric symptoms. Likewise, removal of somatic symptoms which still have an emotional meaning to the patient may cause other symptoms to arise and result in the unmasking of a serious emotional disorder.

Training in Hypnosis

If, indeed, hypnosis deserves a significant place in the practice of medicine today, then it follows that adequate training should be available to interested physicians. What kinds of training have been available in the past, and what is the outlook for the future? Perhaps the biggest problem in the teaching of hypnosis is that induction techniques are so easily taught. With a good instructor, almost anyone can learn to hypnotize in 30 minutes, particularly if he has a readily hypnotizable subject (and this includes 10 to 25 per cent of the general population).

Probably most physicians who have learned something about hypnosis have been taught by the two or three-day weekend seminars given by traveling groups of physicians, dentists and psychologists. Though some of these groups give well-organized demonstrations and practice courses in induction techniques, as well as didactic lectures on the potentiality of hypnosis in medicine, such courses should be considered only as an introduction to the use of hypnosis. These courses give no opportunity for clinical instruction, and an intensive clinical experience, with competent supervision is a *sine qua non* of any good course in hypnosis.

Laymen Presume to Teach

There are also situations in which wholly unqualified and untrained laymen, hypnotists by self-assertion and authorities by sheer audacity, literally roam the countryside seeking to teach hypnosis to any interested "professional individual." Such a per-

son not too long ago made an unsolicited approach to a past president of this medical association offering to impart such knowledge to him. It is preposterous to think that any physician would seriously consider taking a course in "cutting techniques" which would be open only to "qualified individuals," which could include surgeons, butchers, veterinarians, etc., even though these people would supposedly use said techniques only in their own particular line of endeavor. The physician is only too well aware that the mere incising of the abdominal wall is a minor part of a surgical procedure. The anatomy of the region, the function of the organs lying within the abdominal cavity, and the complications that may arise once the abdomen is opened, are of paramount importance. Yet, an analogous situation exists with the teaching of hypnosis, inasmuch as instruction furnished by itinerant groups provides little understanding of the basic phenomenon involved, and certainly, no supervision of the application of the method to patients.

Province of Psychiatry

Cognizant of this situation, the Council on Mental Health, American Medical Association (Committee on Hypnosis) submitted a report² dealing with the problem of training in medical hypnosis. This committee urged that training be under the auspices of medical schools or other teaching institutions. Stressing the interpersonal aspects of hypnosis, the committee stated training would logically fall within the province of psychiatry.

The committee made a number of specific recommendations for a graduate course in medical hypnosis. These included one-half to one day of instruction weekly over a period of nine to twelve months, small classes (four to twelve students), a low student-instructor ratio, and most important, ample opportunity for prolonged clinical experience under adequate supervision. The group noted that experience should be related to the student's field of practice.

Because of the shortage of competent instructors, as well as the expense involved, it has been only within the last several years that any intensive courses have been offered by medical schools. At Tulane University an elective course was offered to senior medical students. They were given an opportunity to learn the techniques and phenomena of hypnosis, as well as to treat selected patients under supervision.⁸ In this situation the students were provided with several hours of instruction and supervision weekly for a period of nine months. The Department of Psychiatry, Emory University School of

Medicine, has recently given an intensive course in hypnosis to its residents. This course was offered to 14 psychiatric residents in the academic year 1960-61. All trainees were given basic didactic instruction in the phenomena of hypnosis and ample opportunity to practice techniques under supervision. The aim here was to integrate hypnosis into the general fabric of the psychiatric residency.

Course Presented at Pennsylvania

The first full-scale course on medical hypnosis to be offered to physicians in practice was given by the Graduate School of the University of Pennsylvania,¹⁰ running one-half day a week for a total of six months. Patients were assigned from the area of medical practice in which the physician was primarily interested (medicine, surgery, obstetrics, etc.) and were closely supervised. The course was taught by the Department of Psychiatry, but in collaboration with appropriate departments of the medical school.

Admittedly, such a program as that at the University of Pennsylvania, does not provide an easy path to becoming an "expert" in hypnosis. It is both time consuming and costly, since a large proportion of the expense must be borne by the trainee. Such a program would probably weed out those who are merely idly curious, attracted by the magic lure associated with hypnosis, but it should provide an excellent opportunity for the practitioner desirous of broadening his skills. Since the results of such training are in direct proportion to the effort expended, it should be expected that the physician who undergoes such a training process would be more than amply rewarded. I would think that any teaching hospital or medical society in this state could set up a program along the lines of the one at the University of Pennsylvania.

I have taken cognizance of the current most substantial medical interest in hypnotism. I have shown that the emphasis placed on psychological problems during World War II played an important role in the development of psychiatry and of hypnosis. I have presented illustrations of current research and practical application of hypnosis. Lastly, I have noted the types of training available and voiced my opinion regarding ways the average physician may secure training in hypnosis.

Summary

Hypnosis, along with other psychological approaches, has been of increasing interest to physicians in recent years. Though spawned in the crisis atmosphere of World War II, it has continued because of the physician's recognition of a need to increase rapport with patients. Limited training has become available for students, residents, and prac-

tioners. The limitations and hazards of certain brief training courses are mentioned and the need for a closely supervised clinical experience is emphasized.

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**APPROVED MEDICAL SCHOOLS
NOW NUMBER EIGHTY-SEVEN**

Two medical schools were added to the list of accredited institutions during the past year, bringing the total to 87, the annual report on medical education of the American Medical Association showed recently.

The new additions are the University of Kentucky College of Medicine, Lexington, and the California College of Medicine, Los Angeles, formerly the College of Osteopathic Physicians and Surgeons.

Approval is granted by the AMA and the Association of American Medical Colleges. There are now no unapproved medical schools in the nation.

The 1961-62 report, prepared by the AMA Council on Medical Education and Hospitals, said "ten or twelve new medical schools are currently being planned.

Five universities—Brown, Rutgers, Connecticut, New Mexico and Texas—are proceeding with plans announced last year to establish two or four-year medical schools.

All States Considering

In almost every state there is some consideration for the possibility of developing new schools within the next decade. Of the many states that have initiated formal or informal considerations of the feasibility of establishing a new school, Arizona, California, Maryland, Massachusetts, Michigan, New York, and Ohio seem most likely to be the sites of new schools in the foreseeable future.

Sixty-seven medical schools completed or began construction of additional facilities in the 1961-62 school year, the council reported. As in the previous year, about three times as much money was allocated for the completion of research facilities as for teaching, "emphasizing again the difference in availability of funds for support of these interdependent but sometimes competing functions," it said.

However, almost twice as many dollars were spent to complete medical service facilities in 1961-62 as in the previous year, and the council said it is "apparent that medical schools are giving increasing attention to constructing and modernizing their hospital and clinical facilities."

Reporting on the number of applicants to medical

schools, the council said a decline was recorded for the fifth straight year.

"The decrease amounted, however, to only sixteen students, hardly a significant number, and it now seems probable that the formerly progressive decline has been checked," it said. "Based upon estimates of applications for the 1962-63 class and increased enrollments in undergraduates colleges, the expectation is that the number of applicants will be shown to have increased for 1962-63 and will continue to increase for several years."

Although various explanations have been offered for the decline in medical school applicants, the council said, "the problem seems to be largely the fact that many new and important careers have opened up for the college graduate, during a period of years in which a relatively small group of men and women reached college age. In retrospect it would appear that this heavy competition for the depression crop of babies should have been anticipated by the profession . . . and accepted with greater equanimity. In spite of the many cries of alarm, there is little evidence that the profession has suffered any real harm through lack of applicants to date."

The total number of students enrolled in medical schools for 1961-62 was 31,078, which represents an increase of 790 students over the previous year, largest increase for any one year since 1951, the report showed. Approval of the California College of Medicine accounted for 355 of the 790 additional students.

Foreign Transfers

A group of students deserving further study are those transferring from foreign medical schools with advanced standing, many of whom are American citizens, the council said.

"While most medical schools still do not consider such applicants, a few schools have admitted selected students on an experimental basis, apparently with generally successful results," it said. "It would seem reasonable to expect more American schools at least to consider such applicants in future years."

Twenty-two such students were admitted to medical schools in this country in the 1961-62 school year.

TRANSVAGINAL ANESTHESIA IN OBSTETRICS

Joel D. Conner, M.D., and Preston Lea Wilds, M.D.,* *Augusta*

■ ***There were no maternal deaths, no post-partum hemorrhages, and no hematoma formations in this series of 112 deliveries.***

THE PURPOSE OF THIS PAPER is to emphasize the usefulness and safety of local anesthesia for labor and delivery. We have been impressed with the value of complete or almost complete pain relief for labor and delivery by the combination of two local blocks, paracervical and pudendal. Both can effectively be given by the transvaginal route as has been previously reported by others.^{10, 14}

Pudendal Block

The effectiveness and safety of transvaginal pudendal block has been reported by Kobak, Wilds and others, who reviewed the neuroanatomy of the perineum and showed that blocking the pudendal nerve at the level of the ischial spines was sufficient to obtain relief from the pain caused by the fetal head distending the vaginal outlet.^{6, 7, 9, 11, 15} Local infiltration of the perineum was unnecessary. Transvaginal pudendal nerve block made technically easier by the development of pudendal needle guides, is now a procedure of established usefulness and popularity. Paracervical block, on the other hand, is only beginning to gain recognition as a clinically useful procedure.

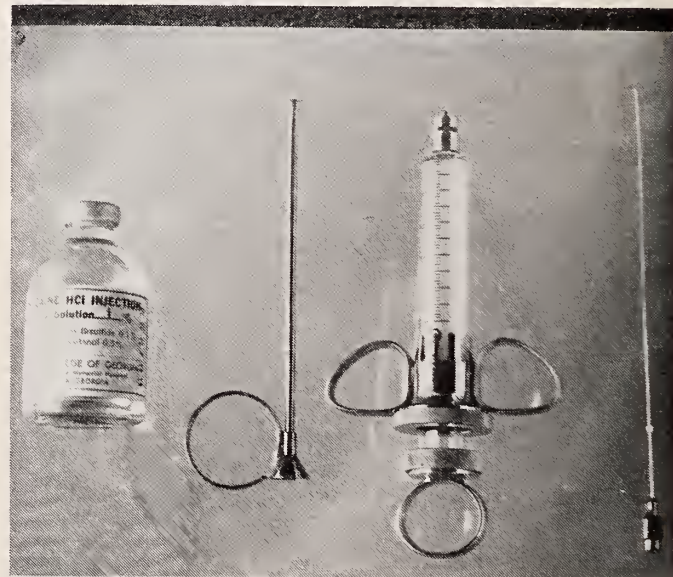
Paracervical Block

The use of local anesthesia around the cervix is by no means a new concept. Gillert and Pribram of Germany, reporting in 1927, were probably the first to describe a series of cases illustrating the technique and effectiveness of injecting an anesthetic solution around the cervix for pain relief during the first stage of labor.³

Rosenfeld in 1945 was the first to describe the procedure in this country.¹³ He used as much as 50 cc of anesthetic solution (usually Nupercaine with adrenalin) and injected deeply into the tissues of the lower broad ligament. He reported good pain relief in all cases but stated that the second stage

of labor was painful. He listed two episodes of fetal bradycardia in his 100 cases.

Since that time the relatively few reports of this procedure have been nearly unanimous in reporting good results.^{1, 4, 8, 10, 12, 14} Kobak concluded that epinephrine was contraindicated in paracervical block because it was associated with fatal bradycardia in five of 32 cases and also, usually with a temporary stop of labor. Spanos took X-rays after injecting a radiopaque material at the four and eight o'clock positions just lateral to the cervix, and



EQUIPMENT

1. 6 inch #20 spinal needle.
2. "Iowa Trumpet" pudendal needle guide.
3. 10cc syringe.
4. 1% anesthetic solution.

Figure 1

Equipment needed for transvaginal anesthesia. From left to right: Anesthetic solution (1%), Iowa Trumpet pudendal needle guide, control syringe, six-inch 20 gauge needle.

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showed that there was a "wide anteroposterior spread of the agent in the broad ligaments just above the level of the lateral vaginal fornices." Kobak, in a recent similar study, has indicated that in obstetric patients, "uterosacral block" and "paracervical block" are essentially the same procedure.

Since the turn of the century, European gynecologists have relieved uterine pain by cutting the sacrouterine ligaments. Campbell has shown the close association of the nerves to the uterus with the uterosacral ligaments.³ Doyle has reported that it is possible to transect or block most of the nerve supply in the terminal 2.5 cm of the uterosacral ligaments.⁵ The chief afferent nerve supply of the uterine fundus is sympathetic. The fibers leave the uterus via the uterosacral ligaments, pass by way of the presacral nerves to the superior hypogastric plexus, enter the lumbar sympathetic chain, and finally pass into the cord at the level of the 11th and 12th thoracic segments. The sympathetic nerve supply to the cervix is the same as that of the fundus. In addition, the cervix is innervated by parasympathetic nerves which enter the cord with the second, third, and fourth sacral roots. Both the sympathetic and parasympathetic nerves thus reach the uterus by way of the paracervical tissues and the sacrouterine ligaments.

Materials

The materials for paracervical block are the same as those we use for doing a pudendal block: a 20 gauge, six inch spinal needle, a ten cc control syringe, a pudendal needle guide (we have been using the Iowa Trumpet), and the anesthetic solution. The agent we have been using is mepivacaine one per cent.

Technique

The paracervical block is preferably given just after the pudendal block. The reason for preceding the paracervical by a pudendal block is to relieve the

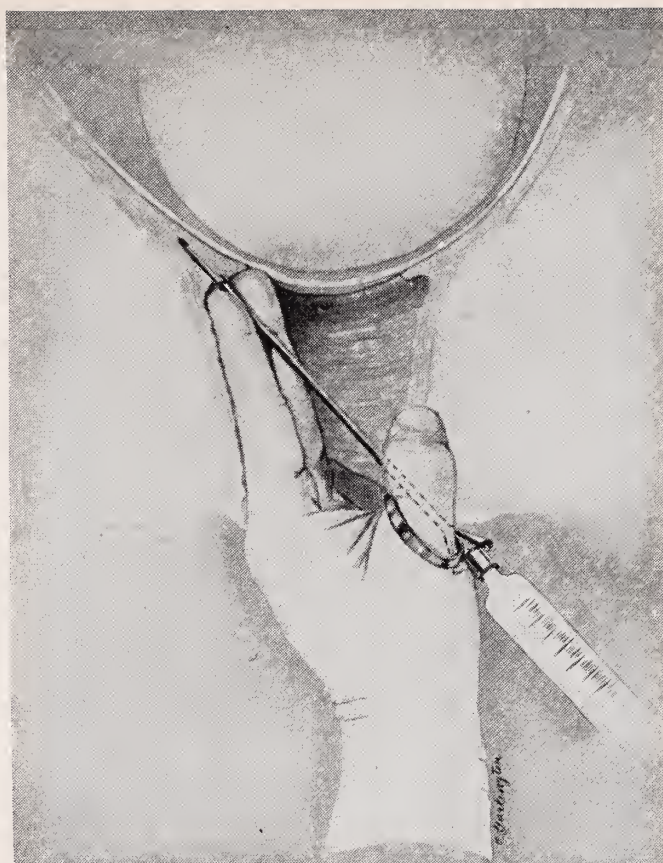


Figure 3

Technique of paracervical block. Note that the position of the ring is reversed so that the guide now lies in the palm of the hand.

mild to moderate discomfort of the patient due to the pressure of the hand pushing in the perineum in placing the needle in the appropriate positions. Also, the pudendal block will control the pain of the second stage labor if the patient should deliver precipitously following the paracervical block. Both blocks may be done as easily with the patient in the labor bed as on the delivery table. The usual perineal preparation for the vaginal examination of the patient in labor is all that is necessary. Figure 2 illustrates the technique for pudendal block; Figure 3 illustrates our paracervical technique. The solution is injected at four and eight o'clock positions in the vaginal fornices. These sites correspond to the position of the uterosacral ligaments, which are displaced laterally as the cervix dilates. Exact placement of the injection is unnecessary, however, and more anterior injections at the three and nine o'clock positions yield equally good results. The needle is introduced through the same guide used for the pudendal block, but with the ring reversed so that the guide lies in the palm of the hand. The patient is allowed to have a contraction before injection of the second side. This will enable one to observe the patient's response, and to detect any untoward reaction before administering the second block. We inject ten cc on each side of the cervix. The block, if successful, gives relief almost immediately, usually with the next contraction. At the completion of the block it is usually convenient to rupture the membranes,



Figure 2

Technique of pudendal nerve block. Note that the syringe and guide are entirely above the hand in the vagina.

provided there are no contraindications. If the block wears off before delivery has occurred, it may be repeated. The return of pain is rapid and not gradual. Patients who have severe discomfort in spite of the block are allowed the usual analgesic drugs.

Indications

The indications for the procedure have not been clearly established in the literature. Page suggests that the main indications for the block should be in patients who fail to respond to the usual analgesic methods and in patients with cervical dystocia or occiput posterior. We have used the block freely, whenever the patient seemed to need pain relief in labor, unless there were a contraindication to the block. We feel that in the following situations paracervical block is especially useful:

- 1) Premature labor, when the usual analgesic agents may produce fetal depression.
- 2) Rapid labor, where immediate pain relief is desirable.
- 3) Hypertonic uterine inertia, as in primigravidas (the block seems to relax the cervix and lower uterine segment).
- 4) Cases in which the patient wants pain relief without sedation, and objects to spinal or epidural regional anesthesia.

Contraindications

We did not administer transvaginal block in the following conditions:

- 1) Amnionitis.
- 2) Third trimester bleeding.
- 3) Uncooperative and unruly patients.
- 4) Allergy to the local anesthetic agent.

Results

In evaluating our results in this preliminary report, one should keep in mind that the blocks were done by different residents rotating through the service and that these residents differed markedly in their experience and interest in the procedure. Our good results under these conditions are evidence that the proce-

TABLE I
Results in 112 Paracervical Blocks

	Primigravidas	Multigravidas
A Excellent	33	24
B Good	6	30
C Fair	4	13
D Poor	1	1
(Totals)	44	68

cedure can be done easily by almost anyone. We graded our cases into four categories, using the same criteria as has been reported previously by others:^{1, 14}

- A) Excellent, no pain or sensation of contractions.
- B) Awareness of mild suprapubic discomfort or backache.
- C) Definite pain relief but still painful and required further analgesia.
- D) No noticeable relief.

Of our 112 blocks in this series, 44 were done on primigravidas and 68 on multigravidas. As shown in Table I, 33 of the 44 primigravidas had excellent results with an additional six getting good results. All but five of the group obtained adequate pain relief so that further sedation was not required (88.6 per cent satisfactory results). Only one of the 44 received no benefit from the block.

On the 68 multigravidas, 24 received excellent and 30 received good results. In this group, there were 13 patients who received some relief but required additional sedation and there was one complete failure. 79.5 per cent of the multigravidas had satisfactory results. Our success rate for the entire series was 83 per cent. Surprisingly, there were no unilateral blocks.

Table II shows that very few of our blocks were given after five cm dilatation. One of the failures was in a primigravida less than five cm dilated, and the other failure was in a 16-year-old seconda gravida at eight cm who delivered 35 minutes after the block was attempted. A minority of previous authors has stated that they believe the block is best given at eight cm or more of cervical dilatation. In general, we disagree with this. In our hands when the cervical dilatation exceeded eight cm the block was often

TABLE II
Success of Paracervical Block Related to Cervical Dilatation

Results	5 cm or less		more than 5 cm	
	Primigravidas	Multigravidas	Primigravidas	Multigravidas
A Excellent	21	16	5	3
B Good	4	18	2	9
C Fair	3	6	0	5
D Poor	1	0	0	1

TABLE III
Cases Where Anesthesia Lasted Until Delivery
Duration of Paracervical Anesthesia

Anesthetic Agent Used	Number of Cases	Duration in Minutes		
		Shortest	Longest	Average
Mepivacaine 1% (200 mgm)	26	10	116	67
Mepivacaine 1% with Phenylephrine .002% (0.4 mgm)	18	40	300	132

difficult. Our results in both primigravidas and multigravidas indicate that the success of anesthesia is unrelated to the degree of cervical dilatation. Furthermore, if the block is withheld until eight cm dilatation the patient usually must endure several hours of unnecessary discomfort.

Table III shows the length of anesthesia in 44 cases given 20 cc of one per cent mepivacaine, with and without an added vasoconstrictor, and whose records were considered accurate and complete. In this series, anesthesia lasted until delivery, and the end-point is therefore the cessation of painful contractions rather than the wearing off of the anesthetic agent. The shortest recorded duration of anesthesia was only ten minutes from completion of the block until delivery. The longest duration was 300 minutes, or five hours. In cases where plain mepivacaine was used, the average duration was 67 minutes; when phenylephrine was added (0.4 mgm. to cc. of anesthetic solution) the length of anesthesia was almost doubled with an average duration of 132 minutes.

In Table IV we have a series of 29 cases in which the anesthesia wore off prior to delivery. In this series, the end-point obviously reflects the true duration of anesthesia rather than the duration of labor after the injection, and though the series is smaller, the results perhaps have greater validity. The shortest duration, without a vasoconstrictor, was 37 minutes; the longest, with a vasoconstrictor, was 270 minutes or four and one-half hours. The average duration without a vasoconstrictor was 87 minutes. When phenylephrine was used, the duration was doubled, with an average of 175 minutes. This difference is statistically significant with a p-value of

less than .001. Figure 4 is a scattergram illustration of our results.

We have used paracervical-pudendal block for a variety of operative obstetrical procedures. In one patient a vaginal septum was surgically excised under paracervical and pudendal blocks without pain. This was followed in 45 minutes by a painless delivery. We have accomplished outlet forceps, mid-

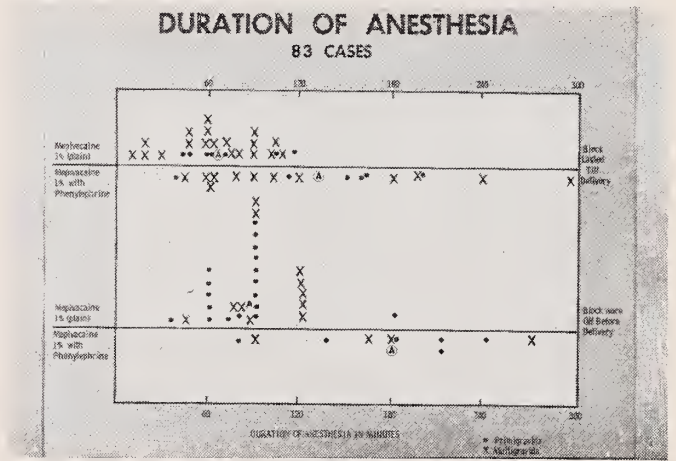


Figure 4
Scattergram of duration of anesthesia.

forceps, manual removal of placenta, breech extraction and manual and instrumental rotation of the occiput posteriors, all under paracervical-pudendal block. We feel that the procedure has a very wide range of usefulness.

It is our impression, as it has been of others, that delivery is often accomplished more rapidly after this block than otherwise. A few primigravidas have gone from two, three, or four cm dilatation to delivery in as short as one and a half hours. We have not attempted a controlled study of this, however.

TABLE IV
Cases Where Anesthesia Wore Off Before Delivery
Duration of Paracervical Anesthesia

Anesthetic Agent Used	Number of Cases	Duration in Minutes		
		Shortest	Longest	Average
Mepivacaine 1% (200 mgm)	29	37	180	87
Mepivacaine 1% with Phenylephrine .002% (0.4 mgm)	10	80	270	175

TABLE V
Complications in 112 Cases

	Mepivacaine Plain	Mepivacaine with Phenylephrine
Fetal bradycardia	1	1
Fetal tachycardia	2	0
Maternal hypertension	0	1
Uterine inertia	1	0

Complications

We had four fetal complications. Table IV shows that there were two cases of temporary fetal bradycardia and two cases of temporary fetal tachycardia. All four infants had good Apgar ratings at birth. The two maternal complications consisted of one case where uterine contractions ceased, and one case of temporary hypertension. The hypertension lasted only about ten minutes and the uterine inertia was treated with oxytocin augmentation of labor. The patient delivered in an hour and 15 minutes. In a few cases maternal hypotension developed after the block with the patient lying on her back. Since this was promptly relieved by turning the patient on her side, the hypotension was attributed to caval compression rather than to the effects of the block itself. There were no maternal deaths, no post-partum hemorrhages, and no hematoma formations in the series.

Other complications which should be considered, but which we did not encounter are:

- 1) Toxicity to the local anesthetic agent (this possibility exists with any such procedure).
- 2) Puncturing the fetal scalp (this should easily be avoided by using the needle guide and careful palpation prior to injection).
- 3) Pelvic hematoma from lacerating a major uterine vessel (uterine arteries are usually retracted cephalad as labor progresses and are beyond the range (1.5 cm) of the needle in its guide).
- 4) Convulsions from intravascular injection (prevented by aspiration before injection).
- 5) Temporary anesthesia over the distribution of sacral plexus (usually not a matter of concern to the laboring patient).

Discussion

The delay in general acceptance of paracervical block as a safe and effective method of pain relief in labor seems to be a result of three factors:

- 1) Technical difficulties in making the injection.
- 2) Toxicity of the anesthetic agents.
- 3) Short duration of anesthesia, requiring repeated injections.

We feel that the use of a pudendal needle guide and a combination of long-acting anesthetic agent and

vasoconstrictor such as we have employed largely invalidates these former objections. The use of this procedure has been too long restricted to specific "indications," whereas in our opinion, the one valid indication in obstetrical patients is relief of pain in labor. The safe use of this procedure requires no more discrimination and covers at least as broad a spectrum of patients as does narcotic sedation. It is probably safer for the fetus.

Fetal bradycardia, which Page encountered in 20 per cent of his series, and which Kobak found to be enough of a problem to contraindicate the use of a vasoconstrictor in paracervical block, was not a serious problem in our series. Two cases of transient fetal bradycardia in 112 deliveries is probably what one might encounter in any series of laboring patients. It may be that epinephrine, which Kobak used, acted either locally or systemically to constrict uterine blood flow, producing placental ischemia and signs of fetal distress, whereas phenylephrine, a less potent vasoconstrictor, was used in our series in just sufficient concentration to prolong the anesthesia without jeopardizing uteroplacental flow (this problem will be explored further in a future communication). On the basis of our experience thus far, it appears that the addition of 0.4 mgm. of phenylephrine to each 20 cc. of anesthetic solution doubles the duration of anesthesia without increasing the risk to mother or fetus. When phenylephrine is used, it is less frequently necessary to repeat the block during labor. This is a gain for both the obstetrician and the patient.

Summary

The effectiveness and safety of transvaginal paracervical and pudendal blocks for pain relief in labor has been reviewed in a series of 112 cases. Satisfactory results were obtained in 88.6 per cent of the primigravidas and 79.5 per cent of the multigravidas. Average duration of paracervical anesthesia with mepivacaine alone was 87 minutes in cases where the effect did not last until delivery. In similar cases, when mepivacaine with phenylephrine was used, the average duration of effect was 175 minutes, or almost three hours. With the longer durations there was no increase in morbidity. The combination of mepivacaine and phenylephrine appears to enhance the practical value of paracervical block as a method of pain relief in the first stage of labor.

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NEW ORLEANS SITE OF 1963 SOUTHERN MEDICAL ASSOCIATION MEETING

The 57th Annual Meeting of the 15,000-member Southern Medical Association, the nation's second largest general medical group, will be held in New Orleans, Louisiana, November 18-21, 1963.

New president of SMA, elected at the 56th Annual Meeting in Miami Beach during the November 12-15 sessions, is Dr. Daniel L. Sexton, St. Louis, Mo. Other officers chosen were Drs. Robert D. Moreton, Fort Worth, Tex., president-elect; R. H. Kampmeier, Nashville, Tenn., first vice president; and Leonidas W. Dowlen, Miami, Fla., second vice president.

Re-elected were executive director Robert F. Butts, and advisor and special consultant, C. P. Loranz, both of Birmingham, Ala.

Dr. Guy T. Vise, Meridian, Miss., is the new chairman of the 17-member governing Council, and elected vice chairman was Dr. Oscar Benwood Hunter, Jr., Washington, D. C.

Members and guests from 40 states, the District of Columbia and six foreign countries attended the Miami Beach meeting for a total registration in excess of 5,000. Some 200 scientific and technical exhibits were presented, illustrating latest advances in medicine, surgery, medical specialties, pharmaceuticals and therapeutic devices.

Council Praises Film

A public telecast, *A Matter of Seconds*, produced by Southern Medical Association and Merck Sharp & Dohme, with the assistance of the National Safety Council and the Council of Aging, was shown for the first time during the sessions. The film, which gives procedures that families can follow to prevent accidents to elderly members in the home, was singled out for high praise by the National Safety Council. Film prints are now available for group presentations through SMA's Film Library, 2601 Highland Ave., Birmingham, Ala.

The Association's committee on scientific work presented the Scale Harris Award for important research accomplishment in the field of internal medicine to Dr. Howard Holley, Professor of Medicine and Head of the Division of Rheumatology, University of Alabama Medical Center, Birmingham, for his contributions toward the understanding of rheumatic diseases, and other aspects of medicine.

Duke Pediatrician Awarded

The Distinguished Service Award of the Southern Medical Association went to Dr. Wilburt C. Davison, Durham, N. C., former Dean and Professor of Pediatrics at the Duke University School of Medicine, for his work in advancing the quality of medical education and the progress of medicine in the South.

In addition to the 21 scientific Section programs, three symposia were given, on *Astromedicine*, *Endocrinology* and *Office Problems*.

Medical student representatives from 21 medical schools in the South attended the meeting as guests of the Association. The student program, begun five years ago with schools participating on a rotating basis, has been gradually expanded, and representatives from all Southern medical schools will be invited to participate in the 57th annual meeting in New Orleans.

Social events of the meeting included the President's Luncheon, where Dr. Edward A. Annis, president-elect of AMA was the guest of Southern Medical president, Dr. A. Clayton McCarty, Louisville, Ky.; the President's Night Annual Dinner, where officers were elected and awards presented; a junior and senior golf tournament, and numerous alumni and fraternity dinners.

The New Orleans meeting will be one of the largest in recent years, and is expected to attract between five and six thousand members and guests.

LET'S START RAISING HELL*

Jenkin Lloyd Jones, *Tulsa, Oklahoma*

LONG BEFORE THE PROPHET, JEREMIAH, uttered his lamentation about the evil behavior of the Children of Israel, the world had seen many calamity-howlers. We have cunieform tablets describing the moral decay of Babylon and Chaldea. We have hieroglyphic inscriptions predicting that Osiris and Ra will smite the Egyptians for their wickedness. And so when I rise today and make some comments about the moral climate of America, and about our responsibilities therefore as temporary custodians of America's press, I speak in a very old tradition.

The calamity howler. It is customary to dismiss such fogeyism as I am about to display with a tolerant laugh. For while it was freely predicted all through the ages that the world was going to Hell, it hasn't gone to Hell yet. Who can deny that in practically all the crafts and certainly all the sciences we are farther advanced than we ever have been? Why not be cheerfully optimistic?

I think I can tell you why. Human progress has never been steady. It has washed back and forth like waves upon a beach. Happily, there has also been an incoming tide, so the waves have washed higher and higher as each great civilization came on.

But the pathway of history is littered with the bones of dead states and fallen empires. And they were not, in most cases, promptly replaced by something better. Nearly a thousands years elapsed between the fall of Western Rome and the rise of the Renaissance, and in between we had the Dark Ages in which nearly all of man's institutions were inferior to those which had gone before. I don't want my children's children to go through a couple of centuries of dialectic materialism before the sun comes up again.

So the Jeremiahs haven't been so wrong, after all.

It is sad to watch the beginnings of decay. It is sad to see an Age of Pericles replaced by the drunken riots of Alcibiades. There was, indeed, just cause for gloom when into the palaces of the Caesars went Nero and Caligula, and when the once-noble Praetorian Guard became a gang of assassins willing to sell the throne to the highest bidder.

Alaric's Goths finally poured over the walls of Rome. But it was not that the walls were low. It was that Rome, itself, was low. The sensual life of Pompeii, the orgies on Lake Traisemene, the gradually weakened fibre of a once-disciplined people that reduced them at last to seeking safety in mercenaries and the payment of tribute—all these brought Rome down. She went down too early. She had much to teach the world.

We Have Much to Teach

And so, ladies and gentlemen, I look upon our own country and much that I see disturbs me. But we are a great people. We have a noble tradition. We have much to teach the world, and if America should go down soon it would be too early.

One thing is certain. We shall be given no centuries for a leisurely and comfortable decay. We have an enemy now—remorseless, crude, brutal and cocky. However much the leaders of the Communist conspiracy may lie to their subjects about our motives, about our conditions of prosperity, about our policies and aims, one thing they believe themselves implicitly—and that is that we are in an advanced state of moral decline.

When Nikita Khrushchev visited Hollywood he was shown only one movie set, that of a wild dance scene in *Can-Can*. He said it represented decadence and I am sure he really thought so. It is a dogma of current Communist faith that America is Sodom and Gomorrah, ripening for the kill.

*This is the text of an address Mr. Jones gave at the Alabama Press Association convention in Birmingham February 9, 1962. Reprinted from July, 1962, issue of *Colorado Editor*.

Do you know what scares me about the Communists? It is not their political system, which is primitive and savage. It is not their economic system, which works so badly that progress in a few directions is purchased at the price of progress in all the rest. It is their puritanism. It is their dedication and self-sacrifice.

No Comfort

It does no good to comfort ourselves with the reflection that these are products of endless brain-washings, of incessant propaganda, of deprivation by censorship and jamming of counter-information and contrary arguments. The dedication is there. The confidence that they are morally superior is there.

The naive questions of your In-tourist guide reveal only too quickly that she is talking to a self-indulgent fop from the court of some latter-day Louis XIV. In the school yard the children rush up to show you, not their yo-yos, but their scholarship medals. And when you offer them new Lincoln pennies as souvenirs they rip off their little Young Pioneer buttons and hand them to you, proud that they are not taking gifts, but are making a fair exchange.

The Russian stage is as austere as the Victorian stage. Russian literature may be corny but it is clean, and it glorifies the Russian people and exudes optimism and promise. Russian art is stiffly representational, but the paintings and the sculpture strive to depict beauty and heroism—Russian beauty, of course, and Russian heroism.

And what of us?

Well, ladies and gentlemen, let's take them one at a time.

For Us: Life Adjustment

We are now at the end of the third decade of the national insanity known as "progressive education." This was the education where everybody passes, where the report cards were noncommittal lest the failure be faced with the fact of his failure, where all moved at a snail's pace like a transatlantic convoy so that the slowest need not be left behind, and all proceeded toward adulthood in the lockstep of "togetherness." Thus the competition that breeds excellence was to be sacrificed for the benefit of something called "life adjustment."

With what results? We have watched juvenile delinquency climb steadily. We have produced tens of thousands of high school graduates who move their lips as they read and cannot write a coherent paragraph. While our Russian contemporaries, who were supposed to be dedicated to the mass man, have been busy constructing an elite, we have been engaged in the wholesale production of mediocrity. What a switch!

When was the last time you, as editors and publishers, examined the curricula of your local schools? How did your schools rank on the standardized Iowa tests? When have you looked at your schools' report cards and the philosophy behind their grading system? Have you asked to examine any senior English themes? Have you offered any recognition to your schools' best scholars to compare with the recognition you accord your schools' best football players?

For the funny thing, "progressive educators," is that theory vanishes when the referee's whistle blows for the kickoff. In the classroom they pretend to grade subjectively, against the student's supposed capacity, lest he be humiliated by natural inadequacy. But on the football field they never put in a one-legged halfback on the theory that, considering his disability, he's a great halfback. They put in the best halfback they've got, period. The ungifted sit on the bench or back in the stands even though they, too, might thirst for glory. If our schools were as anxious to turn out brains as they are to turn out winning football teams this strange contradiction wouldn't exist.

Discipline Rejected

Having neglected discipline in education it was quite logical that we should reject disciplines in art. The great painters and sculptors of the past studied anatomy so diligently that they often indulged in their own body-snatching. And today, after many centuries, we stare at the ceiling of the Sistine Chapel or at the walls of the Reichsmuseum and marvel at their works.

But this self-discipline is of little concern to the modern nonobjective painter. All he needs is pigment and press agent. He can throw colors at a canvas and the art world will discover him. He can stick bits of glass, old rags, and quids of used chewing tobacco on a board and he is a social critic. He can drive a car back and forth in pools of paint and Life magazine will write him up.

Talent is for squares. What you need is vast effrontery. If you undertake to paint a cow it must look something like a cow. That takes at least a sign-painter's ability. But you can claim to paint a picture of your psyche and no matter what the result, who is to say what your psyche looks like? So our museums are filled with daubs being stared at by confused citizens who haven't the guts to admit they are confused.

But the Age-of-Fakery in art is a mild cross that American civilization bears. Much more serious is our collapse of moral standards and the blunting of our capacity for righteous indignation.

Our Puritan ancestors were preoccupied with sin.

They were too preoccupied with it. They were haggard and guilt-ridden and theirs was a repressed and neurotic society. But they had horsepower. They wrested livings from rocky land, built our earliest colleges, started our literature, found time in between to fight the Indians, the French and the British, to bawl for abolition, women's suffrage and prison reform, and to experiment with graham crackers and boomers. They were a tremendous people.

And for all their exaggerated attention to sin, their philosophy rested on a great granite rock. Man was the master of his soul. You didn't have to be bad. You could and should be better. And if you wanted to escape the eternal fires you'd damned well better be.

Sin is Imaginary

In recent years all this has changed in America. We have decided that sin is largely imaginary. We have become enamoured with "behavioristic psychology." This holds that a man is a product of his heredity and his environment, and his behavior to a large degree is foreordained by both. He is either a product of a happy combination of genes and chromosomes or an unhappy combination. He moves in an environment that will tend to make him good or that will tend to make him evil. He is just a chip tossed helplessly by forces beyond his control and, therefore, not responsible.

Well, the theory that misbehavior can be cured by pulling down tenements and erecting in their places elaborate public housing is not holding water. The crime rates continue to rise along with our outlays for social services. We speak of underprivilege. Yet the young men who swagger up and down the streets, boldly flaunting their gang symbols on their black jackets, are far more blessed in creature comforts, opportunities for advancement, and freedom from drudgery than 90 per cent of the children of the world. We have sown the dragon's teeth of pseudo-scientific sentimentality, and out of the ground has sprung the legion bearing switch-blade knives and bicycle chains.

Clearly something is missing. Could it be what the rest of the world's children have been given—the doctrine of individual responsibility?

Relief is gradually becoming an honorable career in America. It is a pretty fair life, if you have neither conscience nor pride. The politicians will weep over you. The state will give a mother a bonus for her illegitimate children, and if she neglects them sufficiently she can save enough out of her ADC payments to keep herself and her boy friends in wine and gin. Nothing is your fault. And when the city

fathers of a harassed community like Newburgh suggest that able-bodied welfare clients might sweep the streets the "liberal" editorialists arise as one man and denounce them for their medieval cruelty.

I don't know how long Americans can stand this erosion of principle. But I believe that some of my starry-eyed friends are kidding themselves when they pretend that every planeload of Puerto Ricans that puts down at Idlewild is equivalent in potential to every shipload of Pilgrims that put into old Plymouth. Nations are built by people capable of great energy and self-discipline. I never heard of one put together by cha-cha-cha.

The welfare state that taxes away the rewards of responsible behavior so that it can remove the age-old penalties for irresponsible behavior is building on a foundation of jelly. It is time we stopped this elaborate pretense that there is no difference between the genuinely unfortunate and the mobs of relievers who start throwing bottles every time the cops try to make a legitimate arrest.

Finally, there is the status of our entertainment and our literature.

Dirt, Alias Realism

Can anyone deny that movies are dirtier than ever? But they don't call it dirt. They call it "realism." Why do we let them fool us? Why do we nod owlishly when they tell us that filth is merely a daring art form, that licentiousness is really social comment? Isn't it time we recognized Hollywood's quest for the fast bucks for what it is? Isn't it plain that the financially harassed movie industry is putting gobs of sex in the darkened drive-ins in an effort to lure curious teenagers away from their TV sets? Last week the screen industry solemnly announced that henceforth perversion and homosexuality would no longer be barred from the screen provided the subjects were handled with "delicacy and taste." Good Lord!

And we of the press are a part to the crime.

Standards Set

Last year the movie ads in our newspaper got so salacious and suggestive that the advertising manager and I decided to throw out the worst and set up some standards. We thought that due to our ukase there might be some interruption in advertising some shows. But no. Within a couple of hours the exhibitors were down with much milder ads. How was this miracle accomplished?

Well, it seems that the exhibitors are supplied with several different ads for each movie. If the publishers are dumb enough to accept the most suggestive ones those are what they get.

But if publishers squawk, the cleaner ads are sent down. Isn't it time we all squawked?

I think it's time we quit giving page one play to extra-marital junkets of crooners. I think it is time we stopped treating as glamorous and exciting the brazen shack-ups of screen tramps. I think it is time we asked our Broadway and Hollywood columnists if they can't find something decent and inspiring going on along their beats.

Bawdiness in A Dinner Jacket

And the stage: They raided Minsky's so Minsky's has spread all over town. Bawdiness has put on a dinner jacket, and seats in the orchestra that used to go for six-bits at the old Howard and Nichols' Gayety are now scaled at \$8.80. Oh, yes. And we have lots of "realism." Incestuous Americans. Perverted Americans. Degenerate Americans. Murderous Americans.

How many of these "realistic" Americans do you know?

Two months ago an American touring company, sponsored by the State Department and paid for by your tax dollar, presented one of Tennessee Williams' more depraved offerings to an audience in Rio de Janeiro. The audience hooted in disgust and walked out. And where did it walk to? Right across the street where a Russian ballet company was putting on a beautiful performance for the glory of Russia? How dumb can we get?

We are drowning our youngsters in violence, cynicism and sadism piped into the living room and even the nursery. The grand-children of the kids who used to weep because the Little Match Girl froze to death now feel cheated if she isn't slugged, raped and thrown into a Bessemer converter.

Nations Have Souls

And there's our literature. The old eyepoppers of the past, which tourists used to smuggle back from Paris under their dirty shirts are now tame stuff. Compared to some of our modern slush, *Ulysses* reads like the minutes of the Epworth League. *Lady Chatterly's Lover* has been draped with the mantle of art, and it is now on sale in the corner drugstore to your high-school-age son or daughter for 50c. Henry Miller's *Tropic of Cancer*, which resembles a collection of inscriptions taken from privy walls, is about to join Lady Chatterly. The quick-buck boys have apparently convinced our bumfuzzled judges that there is no difference between a peep show and a moral lecture.

Don Maxwell of the *Chicago Tribune* has recently asked his book department to quit advertising scatological literature by including it in the list of best sellers. The critics and the book publishers have de-

nounced him for tampering with the facts. I would like to raise a somewhat larger question: Who is tampering with the soul of America?

For nations do have souls. They have collective personalities. People who think well of themselves collectively exhibit elan and enthusiasm and morale. When nations cease believing in themselves, when they regard their institutions with cynicism and their traditions with flippancy they will not long remain great nations. When they seek learning without effort and wages without work they are beginning to stagger. Where they become hedonistic and pleasure-oriented, when their Boy Scouts on their 14-mile hike start to hitch, there's trouble ahead. Where payola becomes a way of life, expense account cheating common, and union goonery a fiercely defended "right," that nation is in danger. And where police departments attempt to control burglary by the novel method of making it a department monopoly then the chasm yawns.

Ladies and gentlemen: do not let me overdraw the picture. This is still a great, powerful, vibrant, able, optimistic nation. Americans—our readers—do believe in themselves and in their country.

But there is rot and there is blight and there is cutting out and filling to be done if we, as the leader of free men, are to survive the hammer blows which quite plainly are in store for us all.

Duty of the Press

We have reached the stomach-turning point. We have reached the point where we should re-examine the debilitating philosophy of permissiveness. Let this not be confused with the philosophy of liberty. The school system that permits our children to develop a quarter of their natural talents is not a champion of our liberties. The healthy man who chooses to loaf on unemployment compensation is not a defender of human freedom. The playwright who would degrade us, the author who would profit from pandering to the worst that's in us, are no friends of ours.

It is time we hit the sawdust trail. It is time we revived the idea that there is such a thing as sin—just plain old willful sin. It is time we brought self-discipline back into style. And who has a greater responsibility at this hour than we, the gentlemen of the press?

So I suggest:

Let's look to our educational institutions at the local level, and if Johnny can't read by the time he's ready to get married let's find out why.

Let's look at the distribution of public largesse and if, far from alleviating human misery, it is producing the sloth and irresponsibility that intensifies it, let's get it fixed.

JONES / Continued

Let's quit being bulldozed and bedazzled by self-appointed longhairs. Let's have the guts to say that a book is dirt if that's what we think of it, or that a painting may well be a daub if you can't figure out which way to hang it. And if some beatnik welds together a collection of rusty cogwheels and old corset stays and claims it's a greater sculpture than Michaelangelo's "David," let's have the courage to say that it looks like junk and probably is.

Let's blow the whistle on plays that would bring blushes to an American Legion stag party. Let's not be awed by movie characters with barnyard morals even if some of them have been photographed climbing aboard the Presidential yacht. Let us pay more attention in our news columns to the do something for the good of others.

In short, gentlemen, let's cover up the cesspool and start planting some flowers.

Well, that's the jeremiad. I never thought I'd deliver one of these. I never dreamed I'd go around sounding like an advance man for the Watch-and-Ward society. I used to consider myself quite a liberal young man. I still think that on some people bikinis look fine.

But I am fed up to here with the educationists and pseudo-social scientists who have under-rated our

potential as a people. I am fed up to here with the medicine men who try to pass off pretense for art and prurience for literature. I am tired of seeing America debased and low-rated in the eyes of foreigners. And I am genuinely disturbed that to idealistic youth in many countries the fraud of Communism appears synonymous with morality, while we, the chief repository of real freedom, are regarded as being in the last stages of decay.

A Lesson From History

We can learn a lesson from history. Twice before our British cousins appeared heading into a collapse of principle, and twice they drew themselves back. The British court reached an advanced stage of corruption under the Stuarts. But the people rebelled. And in the wild days of George IV and William IV it looked as though Britain were rotting out again. But the people banged through the reform laws, and under Victoria went on to the peak of their power.

In this hour of fear, confusion and self-doubt let this be the story of America. Unless I misread the signs a great number of our people are ready. Let there be a fresh breeze, a breeze of new honesty, new idealism, new integrity.

And there, gentlemen, is where you come in. You have typewriters, presses and a huge audience.

How about raising hell?

EMORY TO INCREASE RESEARCH SPACE

With the aid of grants from a private foundation and the National Institutes of Health, Emory University has announced plans to increase its research space considerably.

The university plans to let for contract by February the addition of sixth and seventh floors to the Woodruff Memorial Building. The building houses much of the research now being done in medical areas.

The equivalent of one of the floors will be used for cancer research and the remaining space for other medical research, university officials said.

The project will be financed by a grant of \$230,000 from the National Cancer Institute, \$125,000 from a private foundation and \$125,000 from the Health Research Facilities Branch of the National Institutes of Health.

Effort to Meet Needs

The new space is part of an effort to meet needs generated by Emory's rapidly growing research programs. It is expected that Emory will spend over \$4 million on research this year, most of it in science and medical areas financed by grants. By comparison the figure was \$300,000 in 1950.

The new floor for cancer research will permit expansion to include fundamental studies of the effect of various drugs on the structure of the cell, and virus studies utilizing tissue culture as a laboratory tool.

Emory has received another grant of \$180,000 from a private foundation to be used in equipping the new wing of the Emory Clinic just completed and in running special services to it such as chilled water from a central air conditioning plant.

Grant of \$704,000

Emory has received a grant of \$704,000 from the Health Research Facilities Branch of the National Institutes of Health for renovation of the Gray Building at Grady Hospital. This grant must be matched before the university can obtain it. More adequate research facilities for the Emory medical faculty at Grady are a major need in the medical school's expanding research program.

The school has also received a grant of nearly a million dollars from the same agency for adding a new wing to the Woodruff Building. To match this and construct the wing an additional \$1.5 million will be required.

1963 CALENDAR OF MEETINGS

State

October 23, 1962-March 14, 1963—Series of Postgraduate Courses presented by the Medical College of Georgia's Department of Continuing Education: February 12-14 — "Growth and Development — Management of Common Behavior Disturbances;" March 12-14—"Gynecologic Problems in Private Practice."

February 17-20, 1963—Atlanta Graduate Medical Assembly, Atlanta Biltmore Hotel, Atlanta.

March 11-13, 1963 — Second Annual Postgraduate Course, "Cardiology for the Pediatrician," sponsored by the Department of Pediatrics, Emory University School of Medicine, Grady Memorial Hospital Auditorium, Atlanta.

March 28-30, 1963—Annual Meeting of the Georgia Society of Ophthalmology and Otolaryngology, General Oglethorpe Hotel, Wilmington Island, Savannah.

May 5-8, 1963—109th Annual Session of the Medical Association of Georgia, Aquarama, Jekyll Island, Georgia.

Regional

October 1962-November 1963—Fourteen Postgraduate Courses offered by the University of Tennessee College of Medicine: February 13-15, 1963 — "Emergency Surgery in the Case of the Injured Patient;" March 7-8, 1963—"Urinary Tract Diseases—Diagnosis and Treatment."

January 20-25, 1963—American Academy of Orthopaedic Surgeons, Americana Hotel, Bal Harbour, Miami Beach, Fla.

February 14-16, 1963—American Society of Clinical Pathologists, New Orleans, La.

March 6-9, 1963—American Orthopsychiatric Association, Inc., Shoreham Hotel, Washington, D.C.

March 18-21, 1963—Southeastern Surgical Congress, Americana Hotel, Miami Beach, Fla.

March 22-27, 1963—North American Clinical Dermatologic Society, Diplomat, Hollywood, Fla.

March 24-28, 1963—International Anesthesia Research Society, The Americana, Bal Harbour, Miami Beach, Fla.

March 29-31, 1963—American Otorhinologic Society for Plastic Surgery, Fountainebleau Motor Hotel, New Orleans, La.

April 1-5, 1963—Thirty-sixth Annual Spring Congress in Ophthalmology and Otolaryngology sponsored by the Gill Memorial Eye, Ear, Nose and Throat Hospital, Roanoke, Va.

April 17-20, 1963—Sixteenth Annual Meeting of the West Virginia Academy of Ophthalmology and Otolaryngology, Greenbrier Hotel, White Sulphur Springs, West Va.

National

January 18, 1963—American Society of Facial Plastic Surgery, Hotel Elysee, New York City.

January 21-25, 1963—The American College of Physicians Postgraduate Course No. 8, "Diseases of the Blood Vessels and Problems of Thromboembolism—Treatment and Diagnosis," Cornell University Medical College and New York Hospital, New York City.

January 24-26, 1963—Symposium on Genetics and Heart Disease sponsored by the Heart Association of Southeastern Pennsylvania, Hotel Sheraton, Philadelphia, Pa.

February 2-6, 1963—Congress on Medical Education, Palmer House, Chicago, Ill.

February 6-8, 1963—American Academy of Occupational Medicine, Sheraton-Lincoln Hotel, Indianapolis, Ind.

February 7-9, 1963—Society of University Surgeons, Seattle, Wash.

February 28-March 3, 1963—College of American Pathologists, Rice Hotel, Houston, Tex.

February 28-March 4, 1963—American College of Cardiology, Ambassador Hotel, Los Angeles, Calif.

May 13-15, 1962—Annual Meeting of the American Thoracic Society in Conjunction with the National Tuberculosis Association, Denver, Colorado.

March 17-22, 1963—American College of Allergists, The Americana, New York City.

March 24-29, 1963—American College of Allergists Graduate Instructional Course and Nineteenth Annual Congress, Americana Hotel, New York City.

March 29-31, 1963 — American Society of Internal Medicine, Brown Palace Hotel, Denver, Colo.

March 29-April 4, 1963—American Academy of General Practice, Chicago, Ill.

June 16-20, 1963—American Medical Association Annual Meeting, Atlantic City, N. J.

**Whatever happened
to handkerchiefs?**



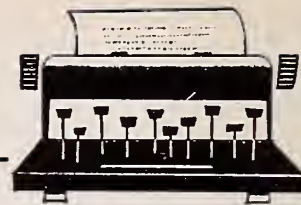
Remember when handkerchiefs were used for stuffy or runny noses? *That was before Naldecon.* Naldecon lets your head-cold patient breathe the way he should. Through the nose. Honest relief that lasts up to 8 hours with one sustained-action tablet. (When you need it, even *half* a tablet retains the sustained-action feature.) The counterbalance between *two* antihistamines and *two* decongestants* usually gives excellent results—seldom causes overstimulation or sedation. Keep handkerchiefs for showing. Prescribe Naldecon.

*Each tablet contains phenylephrine HCl 10 mg., phenylpropanolamine HCl 40 mg., phenyltoloxamine citrate 15 mg., chlorpheniramine maleate 5 mg.—half in the outer layer, half in the sustained-action core. Each teaspoonful (5 cc.) of Naldecon Syrup contains the equivalent of one-half tablet.

NALDECON[®]
long-acting nasal decongestant/
antihistamine

BRISTOL LABORATORIES
Div. of Bristol-Myers Co.
Syracuse, New York





Smoking and Bronchogenic Carcinoma

IT IS BELIEVED BY MANY INVESTIGATORS that the inhalation of cigarette smoke is an important factor in the production of carcinoma of the bronchus. Burney, former Surgeon General of the United States Public Health Service, implicated smoking as the principal etiological factor in the increase in lung carcinoma.

Group Will Review

Recently the government's Advisory Committee on Smoking and Health was filled by the appointment of ten scientists and physicians by Surgeon General Luther L. Terry of the United States Public Health Service. The first action by the group will be a thorough review of all available information on smoking and other environmental factors that may affect health. This is expected to be completed by mid-1963 and is to be followed by recommendations for action.

It is evident from medical literature that the formerly relatively uncommon bronchogenic carcinoma has become a major cause of death in males. It now accounts for one in three deaths due to carcinoma in males 50 to 60 years of age. In addition, it is occurring in younger men 20 to 35 years after initiation of smoking.

Two types of carcinogens have been demonstrated in tobacco smoke: one of these are tars capable of provoking tumors when painted on the skins of mice, and the other is arsenic which is known to elicit cancer in the human skin.

Interestingly, in mice exposed for long periods to tobacco smoke, lung cancer has failed to develop.

Atypical Cells Found

In a very exhaustive study of the bronchial epithelium of humans dying with and without lung carcinoma, atypical cells were found within the bronchial epithelium. There was a tremendous increase in the number of atypical cells with increased

amounts of cigarette smoking. From this study based on histologic evidence, it was concluded that the findings strengthened the already overwhelming epidemiological evidence that cigarette smoking is a major factor in the causation of bronchogenic carcinoma.

A man who smokes two packages of cigarettes per day has a one in ten chance of developing carcinoma of the lung. This is a rate which is sixty times greater than for men who never smoke. This fact should be enough to convince the skeptic; however, it likely will not.

Prevalent Respiratory Disease

Aside from the relationship to pulmonary neoplasia, it was observed that cigarette smokers had a prevalence of chronic respiratory disease substantially greater than that in nonsmokers of similar age and sex.

Assuming the evidence to be true, it would appear that the greatest hope for reducing the mortality of bronchogenic carcinoma is in the dissemination of these facts to young people in an effort to convince them of the hazards of smoking.

It is evident that we find ourselves in a most paradoxical situation in which large sums are spent to detect early carcinoma and to treat advanced carcinoma, yet we are able to do little in the way of (excessive) use of a substance which is directly related to the production of one of the most lethal of human cancers.

The old adage, "The road of excess leads to the palace of wisdom: one never knows when he has had enough until he has had more than enough" seems a propos.

John T. Godwin, M.D.

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3. Anderson, Donald O., M.D., and Ferris, Benjamin G., Jr., M.D.: 267: 787-794, 1962.

"It Is Better To Light One Candle . . ."

SOME MONTHS AGO YOUR State Medical Association urged the component County Medical Societies to encourage physicians to speak out and inform the public on matters of scientific importance and problems of better health care. It is vital to the public's understanding of medicine that the profession itself discuss these matters in open forum. And certainly the profession's viewpoints on controversial matters such as the King-Anderson type health care of the aged need clarification.

An Aim

To achieve this aim, County Medical Societies were requested to furnish physician speakers for civic club meetings, professional club meetings, P.T.A. programs, etc. In an effort to record this activity, the *Journal* has published a map of the state with stars indicating where such presentations by doctors were made. While it is too early to fully assess the results

of this plan, it is all too apparent that the MAG membership is "letting George do it."

If physicians are somewhat dismayed about the misinformation and misunderstanding of scientific advancement in the healing art; if physicians are cast in the role of opposing legislative measures; and if physicians find out that the general public is not aware of their positive programs of health care—then let them *speak out* and light one candle rather than curse the darkness.

Representative Stars

In summary, let us emphasize that stars on the map represent public enlightenment. It is part of the practice of medicine to preserve the healing art and it behooves each doctor of medicine to assume his responsibility in informing the public. So light the candle and let the public know medicine's story throughout the state.

Speak up, doctor.

The Battey Strain of Atypical Acid Fast Bacilli

IN THE MEDICAL LITERATURE, and at medical meetings throughout the country and the world, one reads and hears about the Battey strain of mycobacteria. Almost every article that is written on this subject refers to the basic work and medical pioneering by a team of doctors at our own Battey State Hospital for Tuberculosis. Do we doctors in Georgia know the significance and importance of this particular strain of mycobacteria? It has been identified as causing a new and formerly undescribed type of human disease related to pulmonary tuberculosis but with characteristics entirely different from our old concepts of the disease. Typical pulmonary tuberculosis is coming under better control but at the same time this has happened, new problems have arisen, namely this new disease of the lungs which discharges acid fast bacilli that will not infect a

guinea pig. These bacilli are highly resistant to drugs, and are almost non-contagious. This disease must be attacked by surgery whenever possible. It is due to an organism which resembles tuberculosis on direct smear, but its cultural characteristics soon show that this is not the ordinary or typical tubercle bacillus.

Terminology

First, as to terminology, one hears of atypical acid fast bacilli. This is the term generally used. Some writers do not like this term, which might signify a very close relation to typical tubercle bacilli. Other terms that have been used are unclassified mycobacteria and non-pathogenic acid fast bacilli. None of these designations are helpful and recently the term anonymous mycobacteria is being used. A new book by one of the authorities in this field has just

EDITORIALS / Continued

come out with this term as its title. A large group of bacilli have been found which are as yet unnamed. One large and important group of these has been named, i.e., the Battey strain.

The present classification divides these mycobacteria into four large groups with separate and distinct cultural and often clinical characteristics. One of these groups is the Battey strain or Group III. The classification is based on the cultural properties. The first two groups are affected by exposure to light and become brightly pigmented. The third, or Battey strain, is not affected by light and has little or no pigmentation. The fourth group is distinguished by little pigmentation and very rapid growth.

State of Confusion

Eight years ago the entire field was in a great state of confusion. Isolated cases were being reported of this strange and different malady that was turning up in tuberculosis sanatoria. It was during this time of confusion that the team workers from Battey State Hospital made and published an important and thorough study. Dr. Horace E. Crow, Jr., Dr. Coleman T. King, Dr. C. Edwin Smith, Dr. Raymond Corpe and Dr. Ingrid Stergus published the article in *The American Review of Tuberculosis and Pulmonary Disease* in 1956. This described 69 patients with atypical acid fast bacilli in the sputum over the period 1950 to 1955. This represented one per cent of all admissions to the hospital over these years. The authors described the clinical epidemiologic and pathologic features of the disease.

Battey Strain Applied

Sixty-four of their organisms were of the same type and it was to this group that the term Battey strain was applied. The strains would not affect guinea pigs. The organisms were resistant to isoniazid before any drug was given. There was no reason to believe that the patients had acquired the infection from contact with an isoniazid-treated patient.

The clinical studies showed that most of the patients were white, 60 out of 69. Only two patients

were under 30 years of age, and the peak incidence was in the 60 to 69 year age group. The brief complaint was cough in a large percentage of the cases. Family and marital histories were generally negative for tuberculosis. There was a strong history of previous respiratory disease. Thirty-two per cent failed to react to first strength Old Tuberculin by skin test. The X-ray findings were indistinguishable from active pulmonary tuberculosis. Those treated with isoniazid had a very low conversion rate, and the X-rays did not show much improvement on treatment. Surgical procedures were performed on 13 patients and it was from this experience that present-day treatment is based. The pathological specimens were studied and the findings were identical with those of infection due to *Mycobacteria tuberculosis*. The organisms were recultured from the specimens and were reidentified as being the same as in the sputum.

Of what importance is this to us as practicing physicians? First, we must be vigilant if we are not to make mistakes in the diagnosis and treatment of tuberculosis and this new relative of tuberculosis. Suppose we found a patient with acid fast bacilli in the sputum and a negative tuberculin? Which would we believe? Suppose we treated the patient on the basis of a direct smear of acid fast bacilli and he failed to improve after months of possibly the wrong treatment. One can see the opportunities for mistake in the care of patients unless we are aware of this atypical disease. The atypical cases at Battey State Hospital were one per cent of the admissions from 1950 to 1955. In some parts of the country the incidence of atypical strains is as high as ten per cent. We are just beginning to realize the implications of this disease, and it is a great field for further study. Finally, we doctors as Georgians should be proud of our colleagues at Rome who have made a world-famous study of a new disease process.

F. L. Neely, M.D.

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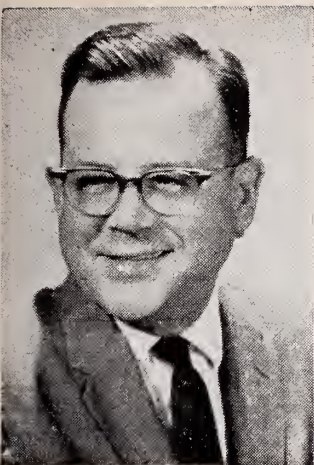
UNITED APPEAL DRIVE SUCCESSFUL

For the first time in the history of the five-county Metropolitan Atlanta United Appeal, the Medical Division has exceeded its quota, Chairman Dr. John Akin, Atlanta, reports.

At the final meeting of the campaign on November 16, Dr. Akin said total pledges from doctors and den-

tists counted up to \$67,593 or 103.1 per cent of the \$65,541 quota.

For the first time in its four year history, the total United Appeal campaign also exceeded its budget. Volunteers brought in gifts and pledges totaling \$3,867.826 or 100.3 per cent of the \$3,857,154 budget.



"PROGRESS THROUGH COOPERATION"

AT THE LAST MEETING of the House of Delegates in Savannah, a resolution was passed favoring the creation of a State Disciplinary Board by the legislature. This Board would be constituted along the same lines as the one now functioning in the State of Washington. Shortly after this proposal was made, a letter was received from the State Board of Medical Examiners opposing such a measure. The position was taken that sufficient authority was already in the hands of the Board of Medical Examiners under the present Medical Practice Act to adequately deal with any conduct problems arising among the doctors of Georgia.

A Review

A review of the State Medical Practice Act revealed this to be true and accordingly a joint meeting of the State Board of Medical Examiners and the executive committee of the Medical Association of Georgia was held in an effort to solve this problem. This meeting was held on October 11, 1962, and it was recommended that the President of the State Medical Examining Board meet with the President of the Medical Association of Georgia, and that the Secretary of the State Medical Examining Board and the Executive Secretary of the Medical Association of Georgia also attend this meeting in the interest of discussing mutual problems concerning the conduct of doctors of medicine in the State of Georgia.

This joint liaison meeting was held on November 29, 1962. Members of the Liaison Committee present were: Carl P. Savage, M.D., Montezuma, President, State Medical Examining Board; Mr. C. L. Clifton, Atlanta, Secretary, State Medical Examining Board; Mr. M. D. Krueger, Atlanta, Executive Secretary of the Medical Association of Georgia; and myself.

Program Recommended

After due discussion and deliberation about the problems of the conduct of doctors of medicine in the State of Georgia and the available disciplinary measures, procedures, etc., it was recommended that

a five point program be suggested to both the State Medical Examining Board and the Medical Association of Georgia for implementation. The joint liaison committee composed of the aforementioned persons was in complete accord on these five following recommendations:

(1) That in the interest of maintaining an understanding of each organization's problems, it is recommended that the Board of Medical Examiners invite to attend certain meetings of the Board, a designated member of the Medical Association of Georgia. Similarly, the Medical Association of Georgia would so invite a designated member of the State Board of Medical Examiners to attend certain meetings of its Council, Executive Committee and Professional Conduct Committee. In this way, the two organizations working for a common purpose would maintain a proper and effective liaison on matters of disciplinary action affecting the practice of medicine in the State of Georgia.

(2) That in those cases of a physician's conduct requiring investigation the following procedure be instituted:

(a) that when the practitioner is a member of the Medical Association of Georgia, the County Medical Society having jurisdiction over this practitioner and the State Medical Association of Georgia should take full responsibility for initiating the investigation of that physician's conduct; take the proper action within the jurisdiction of the County Medical Society and the State Association concerning disciplinary action; and in those cases deemed serious enough to warrant consideration by the State Medical Examining Board; the Medical Association of Georgia would then turn over the complete file on such practitioner for disposition by the State Examining Board.

(b) that when the practitioner is not a member of the County Medical Society and the Medical Association of Georgia, the State Medical Examining Board should take full responsibility for initiating a complete investigation of the practitioner and would call on the Medical Association of Georgia to

PRESIDENT'S LETTER / Continued

enlist the cooperation of the members of the County Medical Society and the State Medical Association in helping the State Medical Examining Board conduct such a full investigation.

(3) That a brief but comprehensive pamphlet on the subject of Medical Ethics in Georgia be co-authored and sponsored by a joint committee of the State Medical Examining Board and the Medical Association of Georgia and be jointly published by the two organizations for distribution to all physicians in the State of Georgia and medical students, etc. In discussing this recommendation, it was noted that such a project had been undertaken by the Medical Association of Georgia some years ago under the leadership of the then President of the Association, Dr. Hal Davison. It was suggested that this work be used as a start on such a project, if undertaken jointly by the two organizations.

(4) That consideration by both organizations be given to a reapportionment of the Board of Medical Examiners by the Governor of the State of Georgia on a district basis similar to the way in which the

members of the State Board of Health are appointed. It was emphasized that this would take some time to complete so as not to involve any present member of the State Medical Examining Board. It was also brought out that if such a measure were given consideration, the Board would then better geographically represent the State of Georgia and the medical profession at large would feel closer to the membership of the Board in that it would be truly representative.

(5) That these suggestions be considered by the Board of Medical Examiners and the Council of the Medical Association of Georgia and after such consideration that the Liaison Committee as appointed originally meet again to consolidate and implement the suggestions made herein, if approved by both organizations.

It is felt that real progress has been made and it is hoped that this good work can be conducted in the interest of better medical practice in this state.


President, Medical Association of Georgia

EMORY RESPONSIBLE FOR LARGEST OBSTETRICAL SERVICE IN COUNTRY

7,303 babies were born at Grady Memorial Hospital last year.

This means that Emory's department of gynecology and obstetrics now has responsibility for the largest obstetrical service of any medical department in the country.

There are charity hospitals with larger numbers of total births, chairman Dr. Dan Thompson says, but the responsibility for their service is usually divided between several medical schools as at Charity Hospital in New Orleans and Bellevue in New York.

Indigent Need Help

The numbers alone indicate a big responsibility and especially since Dr. Thompson is concerned that his indigent patients receive the best possible care.

"I believe many of the sociological, economic and health problems normally associated with the indigent bear some relationship to care for mothers and their infants," he says. He explains that mothers, for instance, who suffer from malnutrition are more likely to have premature and physically weak infants, more susceptible to disease and less able to compete later.

"The indigent pregnant patient in our society has the greatest problems, she is more likely to be anemic, to have children very close together and to have them both early and late in life. She needs good care very badly but is less likely to get it than private patients."

If we can give her the care she needs, our society will be better off in the future, Dr. Thompson believes. He thinks communities should recognize this.

"When someone comes to my door and says he is collecting for the indigent mothers' drive, then I will be happy."

He notes that his department has contact with 99 1/2 per cent of all indigent patients in Atlanta, Fulton, and DeKalb Counties and that his records, therefore, would provide an excellent way for social workers to pinpoint almost all indigent families in the area.

New Ideas Needed

In the long view, Dr. Thompson thinks there are going to have to be new ideas in obstetrical care if the population explosion on all levels of the community is to be served. By 1970 he expects 13,000 births at Grady alone instead of the current 7,000.

One idea that is being considered, he says, is that of using mid-wives, not the old-fashioned type, but educated ones who have had perhaps three years of college and then several years of special training. Deliveries would be made in hospitals rather than in homes. He says this system is being used in England and that in Sweden, 95 per cent of births are delivered by mid-wives. The mother and child mortality rates are lower than in the U. S.

"Such a system would, of course, have to be regulated—that is, the mid-wives would have to be accredited. The governments do this in England and Sweden but it has been suggested that the American College of Obstetricians and Gynecologists might do this in our country."



NEW BOURNES IN THE PSYCHOTHERAPY OF ANTISOCIAL CHILDREN

Hertha Riese, M.D.,* *Richmond, Virginia*

UNDER THE LEAD OF HEALY, the child guidance movement, initiated in the second to third decade of this century, introduced the benefits gained by the new social sciences into psychological medicine. Psychiatric treatment was made available to the lower middle classes with the definite intent of *preventing* emotional disorders at an early age and therefore at their incipient stages. The family as the first psychological and sociological source of children's disorders and as a source of reference was included into the treatment and entrusted to the psychiatric social worker as his special domain. The original therapeutical model was the psychoanalytic treatment of the neuroses, except for the fact that, in the case of children, parents collaborated with treatment. Criteria of treatability were derived from psychoanalytic thinking. According to these criteria a child qualifies for treatment by adequate intelligence (which is assessed by psychological testing) or in other terms by the capacity for symbolic thinking. It enables him to transfer to the therapist feelings which make the therapist, as it were, the experimental object of verification of all of the child's unsolved previous traumatic experiences. To be able to do so the child must have been able to retain the capacity to "relate." This means that he still confides in and anxiously reaches out for parental figures. The implied hopefulness, though at times deeply buried under serious symptoms, is paralleled by the second requirement, the availability of the parents for cooperation in the child's treatment. Those parents who try to ignore their own contribution to their child's problem still relate to him and the human society whose representative elements are approached for help. The third

criterion of treatability, the capacity for verbal communication, reflects both the child's intellectual as well as social status. Language communication primarily in the social unit of the family reflects its ties with society as a whole.

Communication

The requirement that a treatable child must be able to communicate verbally, yielded to the appreciation that younger children communicate by "performance" as well as to an increasing understanding by psychiatrists of the silent patient's non-verbal communication or of unconscious revelations which accompany speech. The widening circle of atypical children acceptable for treatment was further increased by cooperative parents or in refractory cases the availability of foster homes. More children can be treated in the community and may thus be protected from complete isolation, from a sense of being rejected and from a deepening resentment. Many continue working and functioning socially.

The "Untreatable" Child

The Educational Therapy Center has attempted for the past 19 years to assist the "untreatable" children of the classic child guidance clinic and keep in the community with increasing success those emotionally disturbed children who behave antisocially and who otherwise would have been referred to penal or mental institutions.

The usual child guidance program had to be modified to overcome the tensions of these children and their parents whose mutual relationship with the human society was grossly unsatisfactory.

Intake requirements and procedures were changed. Neither average intelligence nor a tendency to com-

* Psychiatrist-Director, Educational Therapy Center, Richmond, Virginia.

municate is a prerequisite, nor is parental readiness for cooperation. So-called aggressive psychiatric social work is a further unorthodox measure used to promote parental cooperation. Account is taken of the socio-economic and psychopathological motives in view of incorporating this new socio-economic group to whom preventive psychiatry, through the offices of the Educational Therapy Center, extends its services. The parents of the social and antisocial children in whose adjustment the community is interested show symptoms similar to their children. Patient, even respectful understanding must resuscitate a sense of worthiness and belonging as well as a basic faith in humanity inherent in every man. Group therapy attracts these frequently destitute fathers and mothers to solve their unrelieved complexes and their sibling rivalries which they transfer to the community. In our parent-teachers' association they have demonstrated that they can take pride in supraindividual projects, work for them with consistency and enthusiasm and raise funds among them and in the community for the benefit of clinic projects.

Deprivation Extreme

Deprivation of these children formerly considered as untreatable frequently is extreme. They may have been deserted by both parents. Most of them function below or far below their mental potentials. In treatment they may rise 20 to 30 points above their original intelligence score. This treatment must gratify concrete and elementary needs as well as promote more elevated human goals. The children do not recognize their elementary needs easily at times for reasons of pride. To be given food for lunch means loving acceptance, a nickel for an errand reciprocation of dedication; clothes represent respectability.

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

"FOOTBALL INJURY" PAMPHLET AVAILABLE

A fourteen page pamphlet on "Football Injuries" has been prepared by Mead Johnson Laboratories and is available free to team physicians who request it. The prevention, detection, and treatment of all common injuries as well as physical conditioning and heat exhaustion are discussed.

The pamphlet, designed to assist team physicians in reducing the risk of player injury, can also be used as a practical guide for trainers and coaches who bear heavy responsibility in preliminary care of the seriously

In our 19 years' experience, a day care program integrated with the usual child guidance approach was found to be a satisfactory answer to both these children's basic needs and their higher, more sublimated goals. Instead of an average of one hour a week they are exposed to a professional dedication of 35 hours a week. They live for most of the day with teachers, parental models trained to understand their abnormal behavior or ambivalence in terms of their life histories and of the symbolic meaning of their "acting-out," that is, non-verbal communication with a more or less negativistic connotation. They slowly acquire civilized expressions of living, of relating and understanding their age group as well as the adults who guide them. They are taught at the level of their emotional and mental maturation by making palatable and desirable a world they have so far learned to distrust and reject. Recreational activities are geared to develop their unexplored sensorimotor potentials, their self-expression and a give and take relationship through the artistic or trade work of their hands. Happily engaged in their teachers' presence in shaping the present moment, in view of the future, they learn to delay impulsive acts and master their anxiousness. They now are capable of keeping in mind and rehearse by inner speech what they will talk about with their psychotherapist. Language as a means of communication and of exploring problems develops, whether by word or play, whether in individual or in group sessions. Learning to delay their impulses is a basic prerequisite for substituting the power of reasoning for the violence of acting out. Motivation for the development of such strength can come only from the child's fond and grateful awareness that he is genuinely accepted and found worthy of all the gifts of love and learning offered to him. Truant children will attend daily. They prefer the clinic atmosphere to hostile and destructive misery in the streets.

injured when the physician is absent, and who often treat minor injuries.

Another pamphlet from Mead Johnson, "The Liquid Pre-Game Regimen," discusses the use of a liquid meal (Sustagen) in the conditioning and training of athletes.

Both pamphlets are available to physicians who write:

Professional Services Department
Mead Johnson Laboratories
Evansville 21, Indiana



PREVENTION OF PULMONARY EMBOLISM

John L. Elliott, M.D., *Savannah*

THE NEED for a definite program to prevent pulmonary embolism can be more fully appreciated after a brief review of the incidence. It is generally conceded that atherosclerosis and phlebosclerosis play an important role in the development of thromboembolic disease and the incidence of both seems to be increasing.

In this country, the estimated deaths from pulmonary embolism each year exceed 34,000. It has been found at necropsy in ten per cent of patients who died in a general hospital. It is the direct cause of death in three to five per cent of all those who die following surgery. The incidence increases markedly in certain groups. It is the direct cause and death in five to seven per cent of all those who suffer coronary thrombosis and accounts for five to seven per cent of maternal deaths. It occurs more frequently after the age of forty years. Twenty-five to 50 per cent of patients bedridden for long periods of time develop thrombi in the deep veins of the pelvis and legs. Ceelin has stressed the frequency of pulmonary embolism in the presence of venous thrombosis and points out that careful dissection of the pulmonary arteries would probably reveal emboli in 75 per cent. In 1946, 42 per cent of the deaths on the urological service at the Henry Ford Hospital were due to pulmonary embolism.

Combination of Factors

Atherosclerosis and venosclerosis result from a combination of factors. Among the factors presently implicated are heredity, diet, weight, exercise, morphologic and chemical anatomy of the blood, sex, and nervous tension. The caloric intake and the fat intake are two of the more important factors about which something can be done. Experiments show that saturated animal fats and hydrogenated vegetable

fats will raise the blood cholesterol while unsaturated fats of vegetable and marine origin tend to lower the cholesterol content of the blood.

Many things have been suggested to delay the development of degenerative cardiovascular lesions. Among them the one most generally accepted as being effective is the low calory diet. It seems advisable in the light of the present knowledge to restrict the use of table salt, animal fats and other hydrogenated or saturated fatty acids to an absolute minimum. The fat content necessary to meet caloric and essential fatty acid demands may be made up in large part by the relatively unsaturated fats.

Investigators Agree

Since Virchow, the majority of investigators agree that venous stasis is by far the most frequent precipitating cause of phlebothrombosis, thrombophlebitis and resulting pulmonary embolism. Aging and degenerative vascular changes set the stage. Neoplasms and cachexia increase the incidence. The venous return flow may be impeded by many factors such as failing heart, circulatory failure, lack of muscular activity, loss of muscle tone, lesions of the intima, varicosities, or anything that changes the flow from "laminar" to "turbulent." It may also be slowed by any factor that increases the viscosity or coagulability of the blood, such as hyperlipemia, polycythemia, increase in fibrinogen or platelets, electrolyte imbalance, and dehydration.

The return flow of venous blood can be assisted by gravity, using the Trendelenburg position when feasible during surgery and elevating the foot of the patient's bed 12 inches immediately following surgery, when not contraindicated. In the older patients who have varicosities, loss of muscle tone and perhaps some phlebosclerosis, further support to the

circulation may be accomplished by having the patient wear snugly fitting knee length elastic stockings in addition to the elevation of the foot of the bed and working the feet as though on the treadle of an old type sewing machine.

There are certain other measures which are rather generally accepted and performed in most hospitals. The surgery is done with as little trauma as possible, and no effort spared to protect the veins in the patient's pelvis and lower extremities from trauma. Stirrups and knee supports are well padded, the lithotomy position, when necessary, is used for the briefest time possible. If the operation in this position is necessarily prolonged, the patient's legs are extended and flexed at frequent intervals. Undue pressure on the abdomen is avoided. After the pa-

tient has been returned to his bed he is encouraged to move his feet and legs and is turned about frequently in an effort to avoid prolonged pressure on calf veins. Early ambulation and deep breathing exercises help to hasten the venous return.

When thromboembolic disease develops, it is generally accepted that unless definite contraindications exist, anticoagulant therapy should be begun and should be continued until the danger of embolism has passed. Venous ligation may have definite indications in some instances but there is much disagreement concerning these indications.

Most investigators agree that the incidence of pulmonary embolism can be markedly reduced by the consistent use of these methods of prevention, as they may be applicable to both medical and surgical patients.

Prepared at the Request of the Committee on Professional Education of the Georgia Heart Association.

THIRTY MAJOR DRUG DISCOVERIES ANNOUNCED

More than 30 major scientific achievements this year were credited to the drug industry today by Dr. Austin Smith, President of the Pharmaceutical Manufacturers Association.

Speaking in New York to an eastern regional meeting of the association, which embraces 141 firms manufacturing 95 per cent of the nation's prescription drugs, Dr. Smith said 1962 had been a productive year for better health, and "one in which the pharmaceutical industry could take just pride."

Discoveries Cited

Among the industry discoveries cited by Dr. Smith were three new cancer agents, a life-saving drug for the treatment of shock, a semi-synthetic penicillin which controls a variety of penicillin-resistant bacteria, a new and safer inhalation anesthetic, a live measles vaccine, a visual technique for the detection of syphilis and the first organic bone mixture suitable for use in orthopedic surgery.

Promising work was also done, he said, in basic enzymology, cardiovascular research, laboratory synthesis of steroids and antibiotics, and in the production of vaccines and hormones.

"A good deal of research for human betterment trespassed in other fields," he said, "leading to improvements in agriculture, animal husbandry, chemistry, biology and medical science."

As an example, he cited the work of one company which resulted in medical equipment that permits an increase in the number of open heart operations that can be performed, and other equipment that permits large quantities of blood plasma to be obtained from relatively few donors.

Dr. Smith also reviewed the drug industry's contributions in 1962 to the development of sound drug control legislation; to efforts to learn more about drug safety; to more effective exchange of scientific information; to the nation's wealth and balance of payments; and to schools, hospitals, universities, overseas projects and numerous other endeavors.

Dr. Smith was critical, however, of Department of Defense practice in purchasing drugs abroad.

"As far as I am concerned," he said, "this is false economy. Such purchases not only contribute to the outflow of U. S. gold but also keep Americans from jobs and reduce company earnings and government tax receipts."

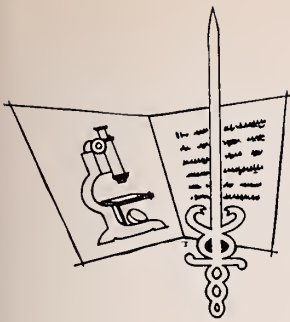
In fact, he said, according to newspaper reports, some of the products of foreign firms are the stolen fruits of U.S. research.

Foreign Purchases

Dr. Smith said a bill to prohibit Government agencies from purchasing drugs from foreign firms that have pilfered U.S. trade secrets had already been introduced into Congress, but he "hoped the Department of Defense can see the wisdom of voluntarily modifying its procurement policies."

Dr. Smith said the drug industry is determined to maintain its leadership in the fight against disease, and said its greatest concern must continue to be the health, happiness and welfare of the greatest number.

His observations were part of an annual report which he, as president of the Pharmaceutical Manufacturers Association, presents to the membership and the public.



CANCER OF THE GALLBLADDER

A. H. Letton, M.D., *Atlanta*

THE DIAGNOSIS OF CANCER OF THE GALLBLADDER has always carried with it a very grave prognosis in the minds of surgeons. Indeed, this is justified, for the five-year survival of this disease varies from 3.5¹ to 5² per cent. With such a low survival rate we must seek some method of earlier diagnosis or more effective treatment in an effort to save more patients who have this disease which kills about 6,000³ persons every year. Various statistics show that cancer of the gallbladder accounts for about four per cent of all cancers, or about 0.45 per cent of all patients coming to autopsy (totaling 908 instances in 206,098 autopsies).³

Early Diagnosis Difficult

Early differential diagnosis is quite difficult because the symptoms are similar to those of chronic cholecystitis with cholelithiasis. There is often a long history of biliary tract disease, frequently of many years duration, with symptoms that the patient has learned to tolerate; but when the patient finally comes to surgery, an unsuspected cancer of the gallbladder is found.

In 1931 Evarts Graham⁴ in his article, "The Prevention of Carcinoma of the Gallbladder," suggested surgery in all patients with stones, whether "silent" or symptomatic, as a prophylaxis against cancer of the gallbladder. Mohardt⁵ lists a number of authors showing the incidence of cancer of the gallbladder containing stones. The reported incidences varied from 1.14 to 15 per cent, the average being about 7.2 per cent. He further lists authors who report incidence of stones in the cancerous gallbladder which varied from 64.6 to 100 per cent, with an average of 87 per cent. The highest incidence of cancer of the gallbladder is found in the sixth and seventh decades

of life. Up to seven per cent of patients with gallstones who reach the life expectancy of 69 years will develop cancer of the gallbladder. With the additional and even more frequent reason of other complications of gallstones, it would seem reasonable to urge cholecystectomy for patients with gallstones, whether or not these stones are causing symptoms. Frequently physicians, who advise patients to have surgery for conditions whose lethal potential is less than the statistical evidence above, will advise their patients to tolerate their gallbladder disease.

Surgery for cancer of the gallbladder, once the diagnosis has been made, is based on the anatomical spread of cancer, although prognosis at the time of surgery is usually poor because of extension to the surrounding tissues. Apparently about 25 per cent of these tumors spread first to the pericholedochal and pancreaticoduodenal nodes, and these nodes must be included in any surgery aimed at eradicating the cancer. The venous spread is about half as frequent as the lymphatic spread, and may be localized in the veins of the gallbladder. The neural spread has about the same incidence as the lymphatic spread, and the nerves in this area should be included in the resection. The intraductal spread is found most often in the papillary type of carcinoma, and should be looked for particularly in this type of lesion. Metastatic disease in the liver is most often found in the portion of the liver next to the gallbladder.

It is apparent, then, that present efforts at lowering the death rate from cancer of the gallbladder must be directed, in a sense, toward a "prophylactic" approach. With the many good reasons for cholecystectomy in addition to the potential for carcinoma, it would seem unjustified to allow patients to continue with symptomatic or asymptomatic stones, and be-

come progressively poorer surgical risks and increasingly more likely to develop complications from their stones.

The patient who is a reasonable surgical risk who has gallstones should have a cholecystectomy without unnecessary delay of this procedure. When cancer of the gallbladder is found, the attempt to eradicate it should include cholecystectomy accompanied by dissection of the lymph drainage area, excision of the adjacent liver, inclusion of the nerves in the area,

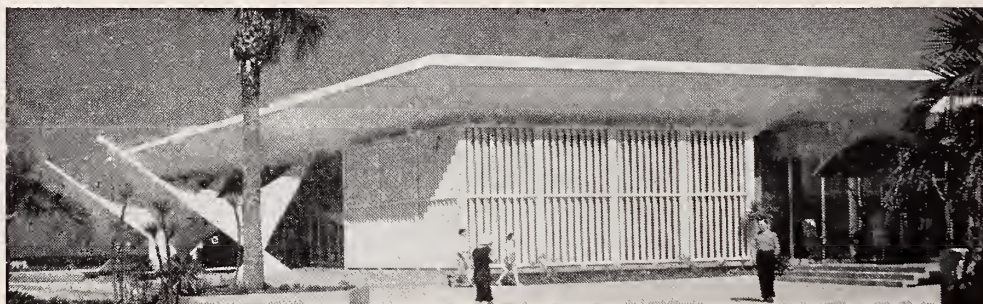
and resection of the involved ducts, if the degree of extension of the tumor makes this technically feasible.

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2. Fahim, R. B.; McDonald, J. R.; Richards, J. C.; and Ferris, D. D.: Carcinoma of the Gallbladder: A Study of the Mode of Spread. *Annals of Surgery* 156:114, July 1962.
3. Glenn, F., and Hays, D. M.: Carcinoma of the Extrahepatic Biliary Tract. *Surg. Clinics of N. Am.* p. 478, April 1953.
4. Graham, E.: The Prevention of Carcinoma of the Gallbladder. *Annals of Surgery* 93:371, 1931.
5. Mohardt, J. M.: Carcinoma of the Gallbladder Collective Review. *Int. Abstracts Surg.* 69:440, 1939.

Approved by the Professional Education Committee, Georgia Division, ACS.

Don't Let Another Day Go By!



AQUARAMA, JEKYLL ISLAND, GEORGIA

Plan now to attend the 109th Annual Session

of the

MEDICAL ASSOCIATION OF GEORGIA

May 5-8, 1963

Jekyll Island, Georgia



PHYSICIAN'S BOOKSHELF

BOOKS RECEIVED

Flood, Frank B., M.D.; Kennedy, Richard J., M.D.; William, J., M.D.; **MEDICAL RESIDENT'S MANUEL**, Appleton-Century-Crofts, New York, 1962, 311 pp., \$4.95.

Dodson, Austin I., Jr., M.D., and Hill, J. Edward, M.D., **SYNOPSIS OF GENITOURINARY DISEASE**, Seventh Edition, The C. V. Mosby Co., St. Louis, Mo., 1962, 384 pp., \$7.75.

Lennon, G. Gordon, M.D., and Neale, A. V., M.D., **DIAGNOSIS IN CLINICAL OBSTETRICS**, The Williams and Wilkins Co., Baltimore, Md., 1962, 336 pp., \$9.00.

Meschan, Isadore, M.D., and Farrer-Meshan, R.M.F., M.D., **SYNOPSIS OF ROENTGEN SIGNS**, W. B. Saunders Co., Philadelphia and London, 1962, 436 pp., \$11.00.

Williamson, Paul, M.D., **OFFICE PROCEDURES**, Second Edition, W. B. Saunders Co., Philadelphia and London, 1962, 448 pp., \$13.50.

Gordon, Maurice Bear, M.D., **THE ACHILLES REFLEX TEST (A.R.T.) IN THE DIAGNOSIS OF THYROID DYSFUNCTION**, Ventor Publishers, N. J., 1962, 20 pp., 1.00.

Reviews

Medical Department, United States Army Surgery in World War II, **ACTIVITIES OF SURGICAL CONSULTANTS**, Volume 1, U. S. Government Printing Office, 1962, 621 pp. \$6.50.

THIS IS ONE of several volumes published by the U. S. Government Printing Office which concerns the history of the Medical Department of the U. S. Army in World War II and is the first of two volumes to be published dealing with the activities of the surgical consultants during that war.

This particular volume deals with the activities of the surgical consultants and their work in the office of the surgeon general and the extension of the system to the service command in the zone of the interior and to a lesser extent, to their activities in the various field armies overseas. It is beautifully illustrated and well indexed. The book is well written and shows the problems which the surgical consultants faced, in that they were a new type of officer whose chain of command and actual functions were not well defined when they were appointed. It is a book which would interest physicians, who are interested in what actually went on in the Medical Department of the Army in World War II, and also for history buffs, who are interested in all the aspects of World War II.

Duncan Shepard, M.D.

Redo, S. Frank, M.D., **SURGERY OF THE AMBULATORY CHILD**, Appleton-Century-Crofts, Inc., New York, 1962.

THIS IS A BRIEF but wide-ranging book covering both surgical emergencies and elective surgical problems in children which should or should not be handled on an ambulant basis. It is written for the pediatrician, the general surgeon and the general practitioner who might be confronted with these pressing problems in children.

The author devotes a chapter each to the preoperative materials and preparation for minor surgery, various inflammatory lesions, soft tissue tumors, burns and bites. Included in the last chapter is a most needed

subject, "The Care of Ostomies," such as tracheostomies, gastrostomies, ideostomies and colostomies. He has thoughtfully included detailed photographs of an ileostomy bag; its care and application.

This reviewer takes issue on several points, hopefully without detracting from the book's generally worthwhile purpose. His advocacy of local anesthesia for surgery in acute tenosynovitis of the hand is not generally accepted. Also, the excision of capillary hemangioma under local anesthesia is, in most surgeons hands, considered difficult.

This book serves as a ready reference to the pediatrician or practitioner whose surgical background is limited, and who has to make a decision to treat wisely the child who is brought to him with a surgical condition.

Gerald T. Zwiren, M.D.

Allen, Edgar V., M.D.; Barker, Nelson, W., M.D.; Hines, Edgar A., Jr., M.D.; **PERIPHERAL VASCULAR DISEASES**, Third Edition, W. B. Saunders Co., Philadelphia and London, 1962, 1044 pp., \$18.00.

ONE SHOULD NOT BE misled by the title of this fine and thorough book which is extensive in its scope. As mentioned in the preface, the purpose is to include all of the vascular system outside of the heart, and the 43 chapters are used for a thorough discussion of the many disease states of these parts of the body. This includes congenital vascular anomalies, infectious problems, traumatic affairs and metabolic and arteriosclerotic disease. The cerebral vascular system, including those vessels leading to the brain, is discussed in detail as well as are the conventional "peripheral vascular" problems. Not only is there a thorough discussion of etiology, pathology and medical treatment but also a presentation of the surgical approach to vascular disease, both direct and indirect.

This extensive coverage of the vascular system makes the book valuable not only as a reference for the practicing physician and surgeon but as a text book for medical students who could strengthen their knowledge by the considerable experience of these authors.

An attractive feature of the book is the inclusion before many chapters of a photograph and brief biography of an investigator. These dedicatory pages are well done and give the reader historical knowledge of many of the men who have been contributors to the advance of the study of the vascular system.

T. Sterling Claiborne, M.D.

Huffman, John William, M.D., **GYNECOLOGY AND OBSTETRICS**, W. B. Saunders Company, Philadelphia, 1962, 1190 pp. \$28.00.

THE BOOK IS A presentation of the subject matter of the combined fields of gynecology and obstetrics. In the space of 1190 pages the author gives a surprisingly comprehensive study of the normal and abnormal phases of both specialties.

Probably the most interesting feature of the book is the manner in which the author combines the two

PHYSICIAN'S BOOKSHELF / Continued

subjects. The reader is given a study of the "life cycle" of Woman. The author begins at conception and carries the reader through the infancy, girlhood, and sexual maturity of Woman and on through her menopause and senescence. The physiology and pathology of obstetrics is presented as one of the phases of womanhood. The chapters which appealed most to the reviewer of the book were those which dealt with applied embryology, anatomy, and histology.

The information in the book gives sound and concise recommendations for the management of gynecologic and obstetric problems. The book is a keen reminder to the physician that he must have a knowledge of the interrelationship of gynecology and obstetrics if he is to treat properly a patient with complaints in either field.

John McCain, M.D.

Edited by Tinsley R. Harrison, Raymond D. Adams, Ivan L. Bennett, Jr., William R. Resnick, George W. Thorn, and M. M. Wintrobe, **PRINCIPLES OF INTERNAL MEDICINE**, 4th Ed. McCraw-Hill Book Company, Inc., New York, 1962, 2,023 pp., \$19.50.

IN TWELVE SHORT YEARS this voluminous textbook has gone through multiple printings and is now in its fourth edition. The new revision maintains the basic ideals set forth for the book in 1950 at its conception. In addition, all chapters have been revised and multiple new chapters added. The statistics are rather impressive—

116 contributors have written 303 chapters which encompass 1947 pages of text plus a splendid cross-index totaling 75 pages.

The first third of the book emphasizes signs and symptoms along with pathophysiology. It is an excellent review of basic clinical sciences. The other two-thirds involves discussion of specific diseases and syndromes. The final chapter lists the most important normal laboratory values for the clinician.

New chapters added for the 1962 edition include: Ocular Manifestations of Systemic Disease, Principle Signs Referable to the Heart, Supportive Tissue Diseases, etc. Latest thinking concerning genetics, carcinoma, malabsorptive disorders, Wilson's Disease, air travel, enteric viruses, etc., is sifted and crystallized for the profession.

In my opinion this is the outstanding general textbook of medicine at the present time. It is of benefit not only to the medical student but also to the house staff, visiting staff, professors, those qualifying for the Boards, and yes, even "detail men!" While not of daily benefit to all specialists, it is hard to conceive of a physician who would not need to consult it in time of crisis.

For convenience-sake the publisher has issued this book in either a one or two volume set. Table reading is recommended to easy-chair study because the sheer weight of present day medical knowledge is uncomfortable on the entrails.

James Z. Shanks, M.D.

WILKINSON: TOO MUCH ATTENTION FOR THE FIT, TOO LITTLE FOR THE NEEDY IN PHYSICAL EDUCATION

Too little for those who need it, abundance for those who don't. That is how Charles B. (Bud) Wilkinson of the University of Oklahoma characterizes physical education programs in secondary schools of the U. S.

Wilkinson Interviewed

Mr. Wilkinson, Oklahoma's director of athletics and coach of the University's enormously successful football team, is chairman of the President's Council on Youth Fitness. He was interviewed on the subject for the current issue of *Medicine in Sports* newsletter.

Programs Lacking

Mr. Wilkinson characterized current school physical education programs as lacking in sufficient time and frequency to be of any benefit. He recommended, "At least 15 minutes of vigorous activity daily for every student with additional time allotted for changing clothes and showering."

In addition, the sports authority noted, "Some sports and games do not provide enough vigorous physical activity. Others encourage students who are already fit to dominate the action while those who need exercise the most merely stand back and watch." He called for more emphasis on activities that develop

strength, stamina and skill while still involving the entire class.

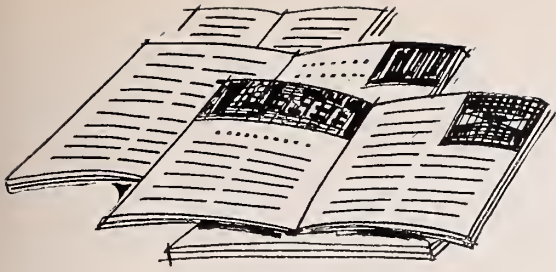
Mr. Wilkinson scored the "reservation of enthusiastic support, good facilities and topflight instruction for those who need them least — the varsity athletes."

Physician's Role

Turning to the physician's role in the school physical education program, Mr. Wilkinson said that the pilot project at Muskogee, Oklahoma, in which local physicians voluntarily examined 5,729 youngsters had shown that less than one per cent of students were disqualified from taking exercise. He noted that two previously undetected heart defects were uncovered in the study and corrected by surgery.

AMA Asks Cooperation

The American Medical Association has called upon all physicians to cooperate with schools in providing health appraisals for every child. Mr. Wilkinson sees this as the doctor's primary responsibility in the school exercise program. But he also stressed the important role that can be played by doctors in educating parents to the importance of exercise to their children's mental and physical well-being.



Versenate Test for Lead Poisoning

THERE IS NO AVAILABLE METHOD for detecting early cases of lead poisoning. Urine and blood lead values overlap between normal children and those with clinical lead poisoning. A method was sought to detect children with elevated body lead stores before they develop clinical signs and symptoms. The 24 hour urinary lead excretions, following intramuscularly administered Versenate, were found to be statistically different from the normal in both children with clinical lead poisoning and those with suspected lead poisoning. This test is proposed as an additional screening method for diagnosis of increased lead exposure before neurological signs and symptoms are manifested.

Whitaker, J. A., Austin, W., and Nelson, J. D.: *Pediatrics* 29:384, 1962.

Change in ABO Antigens

INHERITED CHARACTERS were once thought to remain unchanged during the life of a mammal. Published examples of acquired changes in the ABO antigens are described. A case of chronic lymphatic leukemia, whose red cells changed from group AB to A, is presented. It is speculated that loss of B antigen in this case may have resulted from a somatic mutation of a modifier gene.

Richards, A. G.: Loss of Blood-Group-B Antigen in Chronic Lymphatic Leukemia, *Lancet*, July 28, 1962.

Splenic Rupture in Leukemia

THE CASES OF THREE PATIENTS with acute leukemia who had rupture of the spleen are reported. Diagnostic problems are discussed, and the value of catheter aspiration of the abdominal cavity is shown. Splenectomy was performed successfully in two of the patients.

Tartaglia, A. P.; Scharfman, W. B.; and Propp, S.: Splenic Rupture in Leukemia, *N.E.J.M.*, 267:31, 1962.

Cytomegalic Inclusion Disease and Lymphoma

FOUR CASES OF CYTOMEGALIC INCLUSION DISEASE in children are presented as a rare terminal compli-

cation in two instances of acute lymphatic leukemia, one case of acute leukemia, and one case of lymphosarcoma. Decreased host resistance may have caused the virus to become pathologic in these children.

Incidence of Multiple Renal Arteries On Aortography

THE PRESENCE OF SO-CALLED ABERRANT RENAL arteries has been said to be a contributing factor or source of unilateral renal hypertension. This has not been borne out in the experience of the authors in which translumbar aortograms of 400 patients including 381 with arterial hypertension were found to have no higher incidence of multiple renal arteries than has been recorded generally in anatomic investigations. Patients who have multiple renal arteries have not had a greater incidence of occlusive renal artery disease than patients who have a single artery to each kidney.

James R. Geyer, and E. F. Poutasse: Incidence of Multiple Renal Arteries on Aortography, *J.A.M.A.*, 182:120, 1962.

The Role of the Uterovesical Junction in the Natural History of Pyelonephritis

IT IS POSSIBLE that as high as 50 per cent of all children with recurring urinary tract infections will, with the aid of cinefluoroscopy, demonstrate reflux. Reflux is also being demonstrated more frequently in adults with typical chronic pyelonephritis and during attacks of acute cystitis. Since the prevention of reflux is the responsibility of the uterovesical junction, and depends to a large extent upon the length of the intravesical segment of the ureter, factors which affect this length are important in the prevention and treatment of pyelonephritis. It is possible that the basic defect in most patients with pyelonephritis is a defective uterovesical valve. The obvious implication is that intensive medical therapy for pyelonephritis of childhood with proper surgical correction of anomalies is as important as long term therapy in the treatment of adult pyelonephritis.

John A. Hutch: The Role of the Uterovesical Junction in the Natural History of Pyelonephritis, *Journal of Urology*, 88:354, 1962.

THE ASSOCIATION



DEATHS

EDGAR BROWN DAVIS, 81-year-old Byromville physician, died in a Montezuma hospital November 20, 1962, after a brief illness.

Dr. Davis graduated from the University of Maryland Medical School, interned at Bay View Hospital, Baltimore, and then located in Byromville where he practiced for 58 years. Dr. Davis also operated large farming interests at Byromville.

He was a member of the Byromville Methodist Church which he helped to found shortly after moving to the city.

Survivors include one son, Dr. Edwin B. Davis, New Orleans; and three grandchildren.

JAMES B. BAIRD, retired Atlanta physician, died at his residence December 1, 1962.

An honorary member of the Fulton County Medical Society and a member of the Medical Association of Georgia, Dr. Baird is survived by his wife, Alice Stanley Baird; one nephew Gordon B. Russell, Scarsdale, N. Y.; and a cousin, Mrs. P. S. Speer, Atlanta.

SOCIETIES

BALDWIN COUNTY MEDICAL SOCIETY met October 9, 1962, at Milledgeville. A talk on Modern Trends in Psychiatry was given by Dr. West of the Milledgeville State Hospital. Newly elected officers for the society are, Joseph G. Bohorfoush, President; H. B. Johnston, Vice President; and George L. Echols, Jr., Secretary-Treasurer. Delegates are W. T. Smith, alternate—J. B. Craig, and E. Y. Walker, alterate—George L. Echols, Jr. New three year members of the Board of Censors are Wilbur M. Scott; the tenure of Edwin W. Allen continues for one year, and for Zeb Burrell, two years.

BIBB COUNTY MEDICAL SOCIETY met at Macon October 2, 1962. The program was presented by Dr. Hugh Smisson, Augusta, and was entitled, "Electroencephalography."

CARROLL - DOUGLAS - HARALSON MEDICAL SOCIETY met November 5, 1962, at Tallapoosa and has elected the following officers for 1963, President, Richard Allen; President-Elect, Harold McLendon; Vice President, Floyd Morgan; Secretary-Treasurer, Harvey Beall. After the business meeting a Ladies' Night Banquet was held. Mrs. Mac Martin presented a program on the "Doctor's Image," as obtained by the public from popular communications media.

COWETA COUNTY MEDICAL SOCIETY had as its speaker at the November 13, 1962, meeting in Newnan, Dr. Jack Powell, who presented a case on mesenteric infarction complicated by pneumatosis cys-

toides intestinalis which was recently encountered in the Newnan Hospital. A discussion of the case followed.

FLOYD COUNTY MEDICAL SOCIETY honored new members at its meeting held in Rome November 16, 1962. The honored guests were Dr. and Mrs. Boyce Brice, Dr. and Mrs. Ralph House, Dr. and Mrs. Thomas Jackson, Dr. and Mrs. Richard Leigh, Dr. and Mrs. William Lucas, Dr. and Mrs. James H. Smith, Dr. and Mrs. C. R. Wilcox, Jr., Dr. Kenneth Williams, resident physician at Battey Hospital, and Mrs. Williams, and interns and their wives, Dr. and Mrs. Tom Brown, Dr. and Mrs. Bill Collins, Dr. and Mrs. Ed Fowler, Dr. and Mrs. Dan Sigma, Dr. and Mrs. Tom Theus, and Dr. Jack Macham, Dr. J. C. McRae and Dr. Bill Ford.

MUSCOGEE COUNTY MEDICAL SOCIETY met November 27, 1962, in Columbus to elect new officers for 1963. The new president, succeeding James Rhea is Roy Gibson; R. A. Chipman was elected Vice President; C. D. Johnson, Secretary; John L. Stapleton, member of the Board of Censors; Charles Smith and Bruce Newsome, delegates of MAG, and Robert H. Vaughan and A. B. Conger, alternate delegates.

POLK COUNTY MEDICAL SOCIETY met November 13, 1962, in Cedartown and elected the following officers for 1963. Harold Goldin, Rockmart, President; T. E. Cummings, Rockmart, Vice President; and A. B. Campbelle, Cedartown, Secretary-Treasurer.

RICHMOND COUNTY MEDICAL SOCIETY met in Augusta November 27, 1962, and elected 1963 officers. Incoming President is Preston D. Ellington. Other newly elected officers are Vice President, Cecil A. White, Jr.; Secretary-Treasurer, Henry D. Scoggins; delegates to MAG, Dr. Ellington, A. Jack Waters, and Clyde A. Burgamy; alternate delegates, Dr. Harrison, John R. Fair, and William A. Fuller; Counsellor, Harry D. Pinson; Vice Counsellor, Joseph L. Mulherin; and member of the Board of Trustees, Daniel Sullivan.

SOUTHEAST GEORGIA MEDICAL SOCIETY met September 26, 1962, at Vidalia. The program was presented by a representative of the G. D. Searle Co. who showed two movies, one on the drug, Enovid, and another on the anesthetic agent, Penthrane.

SOUTHWEST GEORGIA MEDICAL SOCIETY met in Blakely November 21, 1962. A scientific program entitled, "Brain Injuries," illustrated with lantern slides, was presented by Dr. Louis Hazouri of Columbus.

THOMAS-BROOKS MEDICAL SOCIETY held its Christmas meeting in Thomasville on December 7, 1962. The program was presented by two members of the Department of Psychology, Florida State University, Tallahassee, Florida. "School Phobia," was the topic of Dr. Wallace Kennedy's talk, and Dr. N. W. Skaja spoke on, "Depression."

TIFT COUNTY MEDICAL SOCIETY held a dinner meeting December 4, 1962, at Tift. Dr. James Miller, who is in charge of the Animal Disease Laboratory, which is connected with the Georgia Coastal Plain Experiment Station, presented the program. The following officers were elected for 1963: President, W. L. Bridges, Jr.; Vice President, Henry K. Jarrett; Secretary-Treasurer, C. S. Pittman, Sr.; delegate to MAG, Robley Smith, and alternate delegate, Ed Aderholt.

PERSONALS

First District

Swainsboro physician, RANDALL G. BROWN, returned to his practice November 2, 1962, after spending a short time in Emanuel County Hospital after having suffered a severely sprained ankle.

FRANK T. ROBBINS of Vidalia introduced and demonstrated a motorized traction unit at the recent Clinical Meeting of the American Medical Association held November 24-28, 1962, at Los Angeles, California. Dr. Robbins presented one of the 60 exhibits in the scientific section.

"Medical Quackery," was the subject discussed by IRVING VICTOR, Savannah, at the November meeting of the Woman's Auxiliary to the Georgia Medical Society.

Second District

No news submitted.

Third District

C. RAY IVEY, JR., recently of Macon, moved November 1, 1962, to Cochran, Georgia, where he has taken over the practice of REID GULLATT.

KELVIN LANE, Ashburn, was the featured speaker at the November 6, 1962, meeting of the Ashburn Kiwanis Club. Dr. Lane spoke on the three classes of drugs which have created social problems among young people and adults.

Fourth District

An East Point physician, W. P. FEDACK, moved his practice to the town of Hampton, Georgia, in December. Dr. Fedack's services were announced at a recent meeting of the Hampton Lion's Club.

Fifth District

At its recent annual meeting, the medical staff of DeKalb General Hospital honored L. C. BUCHANAN, Decatur, retiring as the First Chief of Staff. Dr. Buchanan was presented with an engraved silver bowl.

A. H. LETTON, Atlanta, a Georgia delegate to the English International Cancer Congress in Moscow in July, showed slides of Moscow and East and West Berlin at the First Baptist Church of Atlanta, November 25, 1962.

Named recently as the new Chief of Staff of DeKalb General Hospital was FLOYD R. SANDERS, JR., Decatur.

At the November meeting of the American Academy of Pediatrics held in Chicago, ROBERT S. CAUSEY, JR., Marietta, was elected a Fellow of the Academy.

J. GORDON BARROW, Atlanta, director of medical education at the Georgia Baptist Hospital and director of the cardiovascular disease control program of the State Health Department, was recently appointed vice chairman of the American Heart Association Council on Community Service and Education.

"Alcoholism," was the topic of a talk given by VERNELLE FOX, Atlanta, to the Georgia Medical Society, Savannah, at the November 6, 1962 meeting. Dr. Fox is the Director of the Georgian Clinic for Alcoholism in Atlanta.

A member of the Board of Directors of the American Academy of Dermatology and Syphilology, SIDNEY OLANSKY, Atlanta, was invited to lecture on Venereal Disease at the November meeting of the Academy held in Chicago. In addition to lecturing, Dr. Olansky was the Chairman of the Syphilis panel and led the informal discussion at the Annual Group Meeting of the American Academy of Dermatology and Syphilology.

CHARLES M. HUGULEY, Atlanta, recently presented papers on, "Clinical Management of Hodgkins' Disease and Lymphomas," and "Alkylating Agents, Mechanism of Action, and Clinical Applications," at a postgraduate course at the University of Kansas.

Participating in a discussion on bronchitis and bronchiectasis at the meeting of the Southern Chapter of the American College of Chest Physicians, Miami Beach, November 11-12, 1962, was ROSS L. McLEAN, Atlanta.

Sixth District

The citizens of Jefferson County were invited to an autographing party December 8, 1962, in honor of JOHN RANSOM LEWIS, JR., Atlanta, who has written a book of poetry, *To Dock At Stars*. The autographing party was held at the Jefferson County Library at Louisville.

Seventh District

Attending an open house and receiving guests at the recently opened Watts Clinic in Bowdon were DR. AND MRS. J. W. WATTS, and DR. AND MRS. W. S. GRESHAM.

Eight District

Retiring, after practicing at Baxley for 39 years, is J. T. HOLT. Dr. Holt was honored at a, "J. T. Holt Day," held December 2, 1962, in Baxley.

H. L. DISMUKE, Ocilla, has been elected to a second term as mayor of the city.

Ninth District

No news submitted.

Tenth District

J. KENNETH McDONALD, Augusta, was the speaker at the regular meeting of the Ladies Auxiliary to the Richmond County Medical Society held November 26, 1962, at Augusta. Dr. McDonald spoke on Mental Health.

JAMES W. BENNETT of Augusta, has recently

THE ASSOCIATION / Continued

been elected a fellow of the American Academy of Pediatrics at the November meeting held in Chicago.

An Augusta internist, ALEX T. MURPHY, is the author of an article which appeared in the recent issue of *The New Physician*. The title of Dr. Murphy's article is, "How to Study—A Manual for Medical Students."

ROBERT B. GREENBLATT, Professor and Chairman of the Department of Endocrinology at the Medical College of Georgia, Augusta, has recently been elected a fellow of the New York Academy of Sciences. Dr. Greenblatt has been a member of the Medical College staff since 1935.

MAG BOARD OF INSURANCE AND ECONOMICS MEETING

A MEETING OF THE Board of Insurance and Economics of the Medical Association of Georgia was called to order by Chairman David R. Thomas, Augusta, at 9:50 A.M., November 18, 1962, at the MAG Headquarters Building, Atlanta.

Members of the Board present included David R. Thomas, Augusta; Harry D. Pinson, Augusta; W. L. Pomeroy, Waycross; and William W. Moore, Atlanta. Also present were Mr. John Moore, MAG Attorney; Mr. James Poole, of Poole and Wood Associates, Atlanta; Mr. Frank Miller, Citizens and Southern National Bank, Atlanta; Mr. Eugene Oberdorfer, Benefit Management Consultants, Atlanta; Mr. R. J. Karraker, Georgia Railroad Bank and Trust Company, Augusta; Mr. J. M. Bragg and Mr. E. L. Lord, Life of Georgia, Atlanta; Mr. Eugene Caldwell, Montag and Caldwell Investment Counselors, Atlanta; Mr. Lafayette Davis, Provident Life Insurance Company, Atlanta; and John T. Mauldin, Atlanta. MAG staff members present were Mr. Milton D. Krueger and Mrs. Catherine Wooten.

General Discussion

Chairman Thomas opened the meeting by stating that the new H.R. 10 (Self-Employed Individuals Tax Retirement Act of 1962) would be the subject of discussion at this meeting. It was agreed by the Board that they would receive the presentations of the various organizations offering plans for the implementation of H.R. 10 by the physicians of Georgia, and would then make a decision as to what steps should be followed. Chairman Thomas then called for the first presentation.

H.R. 10—Mr. James Poole, of Poole and Wood Associates, discussed his firm's proposal. Mr. Frank Miller, of the Citizens and Southern National Bank, was asked to comment after Mr. Poole's presentation and he offered the bank's assistance and emphasized that in deciding upon a plan the Board should keep in mind that a bank would be of valuable assistance to each participant.

H.R. 10—Mr. Eugene Oberdorfer, of Benefit Management Consultants, then made his presentation. Mr. Eugene Caldwell, of Montag and Caldwell Investment Counseling Firm, stated that there were many advantages in the employment of investment counselors in the plan suggested by Mr. Oberdorfer.

H.R. 10—Mr. R. J. Karraker, of the Georgia Railroad Bank and Trust Company, Augusta, was given the floor and his plan was discussed.

Each presentee of a plan distributed brochures to the Board for research and study.

H.R. 10 EVALUATION—The Board discussed the three plans suggested but without further study it could not make a decision at this time as to which plan would be most suitable for the membership. It was then recommended that the Board study the plans independently and meet again within a few weeks for more concrete discussion. Chairman Thomas asked Mr. John Moore, MAG Attorney, to draft a letter to the MAG members informing them that H.R. 10 is being studied by the Insurance and Economics Board and that a recommendation will be made after this study has been completed. Mr. Moore is to get Dr. Thomas's approval of the letter before it is mailed to the members.

Life Insurance Company of Georgia Annual Report

Mr. J. M. Bragg presented the annual report and asked for increased enrollment by new members. Suggestions were offered to Mr. Bragg and Mr. Lord by the Board for improvement in the participation by MAG members, such as follow-up letters from the Life Insurance Company of Georgia to a member who has been practicing a year, and whose income would probably be sufficient at that time to warrant his applying for insurance. Dr. Thomas commended the Life of Georgia for their efficient handling of the plan in the past year.

Voluntary Pre-Paid Health Insurance Progress and Problems

Mr. Lafayette Davis, of the Provident Life Insurance Company, suggested that a review committee be appointed to work with the Health Insurance Council. Dr. Moore informed Mr. Davis that an HIC Liaison Committee had been appointed, of which he was Chairman, and that the committee would meet at an early date. Mr. E. D. Lord is to be invited to this meeting.

Connecticut 65 Plan

Dr. Moore inquired of the insurance representatives present, if the Connecticut 65 Plan had been considered on a southeastern regional basis to offer a positive step in the joint efforts of the insurance industry and the medical profession to furnish medical coverage to the over 65 age group. Mr. Davis and Mr. Lord commented that it would be an excellent idea and they felt sure other companies would be interested in such a plan. Chairman Thomas asked Dr. Moore to investigate the possibility of this type of plan for Georgia.

Application of Kerr-Mills Principles to All Ages Resolution

Dr. Mauldin gave the Board information on the Resolution which had been given to the Georgia Delegation for possible submission at the forthcoming AMA meeting in Los Angeles.

Insurance Coverage for Mental Illness

Chairman Thomas read the Resolution presented at the MAG 1962 Annual Session on Insurance Coverage for Mental Illness. This Resolution was forwarded by the MAG House of Delegates to the Insurance and Economics Board for action. After discussion with the insurance representatives present, Dr. Thomas asked Mr. Bragg to render an opinion on this matter.

H.R. 10—There was further discussion as to whether any physician in Georgia would benefit by the group plan. The insurance feature was mentioned as a flexible item with the choice left to the physician. Chairman Thomas stated that a report would have to be made to Council in December and, therefore, another meeting was discussed.

Date and Site of Next Meeting

It was decided by mutual consent of the Board that this meeting would be held in Macon on December 2, 1962, at 10:00 A.M., to discuss H.R. 10. It was thought advisable that more information should be obtained before a recommendation could be made to Council. The following are to be invited to the meeting: Mr. Frank Miller, Citizens and Southern National Bank, Atlanta; Mr. James Poole, Poole and Wood Associates, Atlanta; Mr. Eugene Oberdorfer, Benefit Management Consultants, Atlanta; Mr. R. J. Karraker, Georgia Railroad Bank and Trust Company, Augusta; and Mr. John Moore, MAG Attorney. This meeting would be a Question and Answer Session.

Relative Value Study Committee Plans

Dr. Pinson stated that a questionnaire had been received from AMA to be distributed to 500 physicians in Georgia. The purpose of the distribution of the questionnaire is to make a Relative Value Index Survey to determine if this fits Georgia. The Executive Secretary was instructed to order the questionnaires, secure an analyst to mail the questionnaires, receive the replies and report the results to the Chairman of the Relative Value Study Sub-Committee. The Chairman has designated the number of questionnaires to be mailed to physicians in each specialty.

There being no old and new business the meeting was adjourned at 4:15 P.M.

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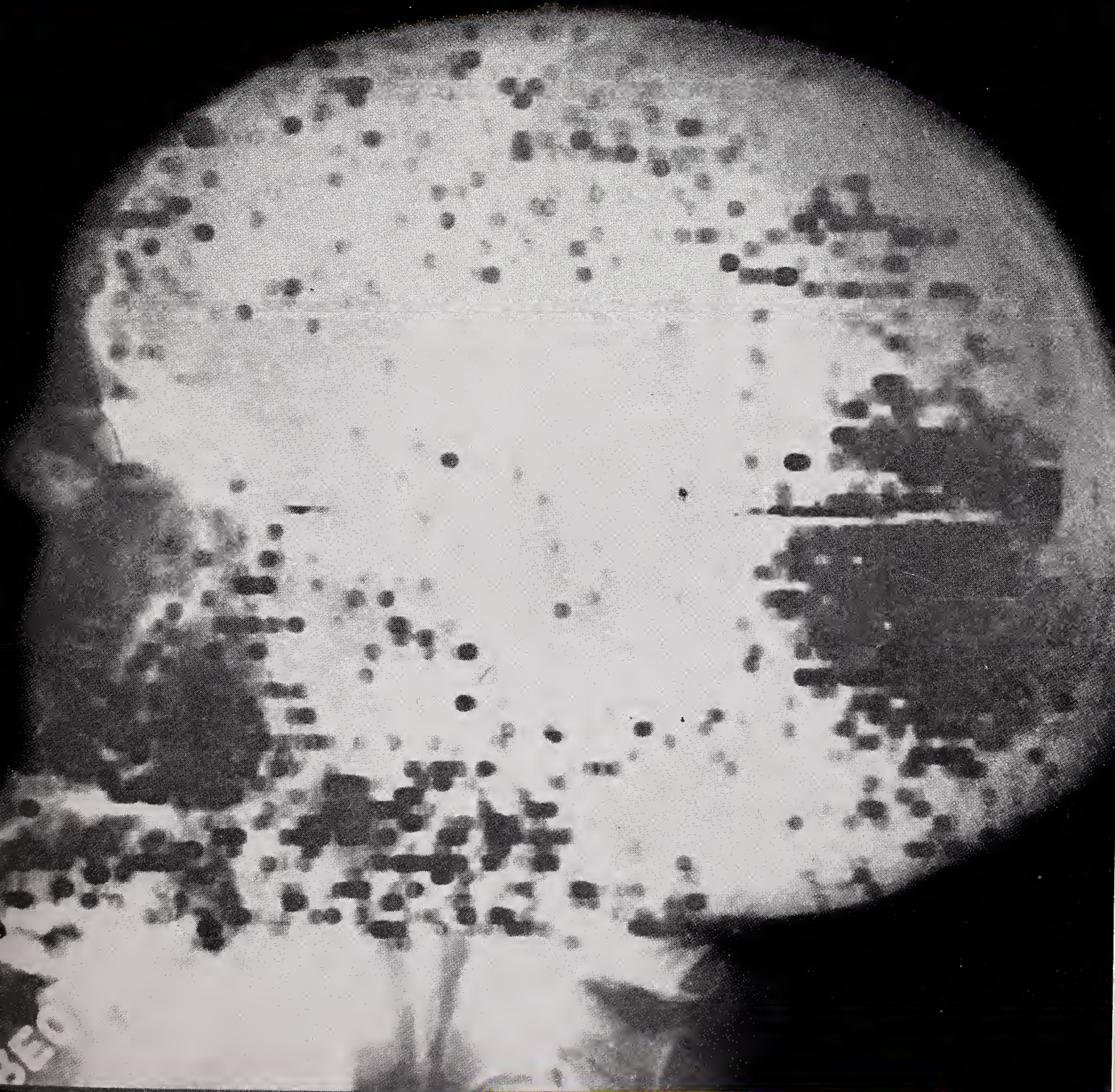
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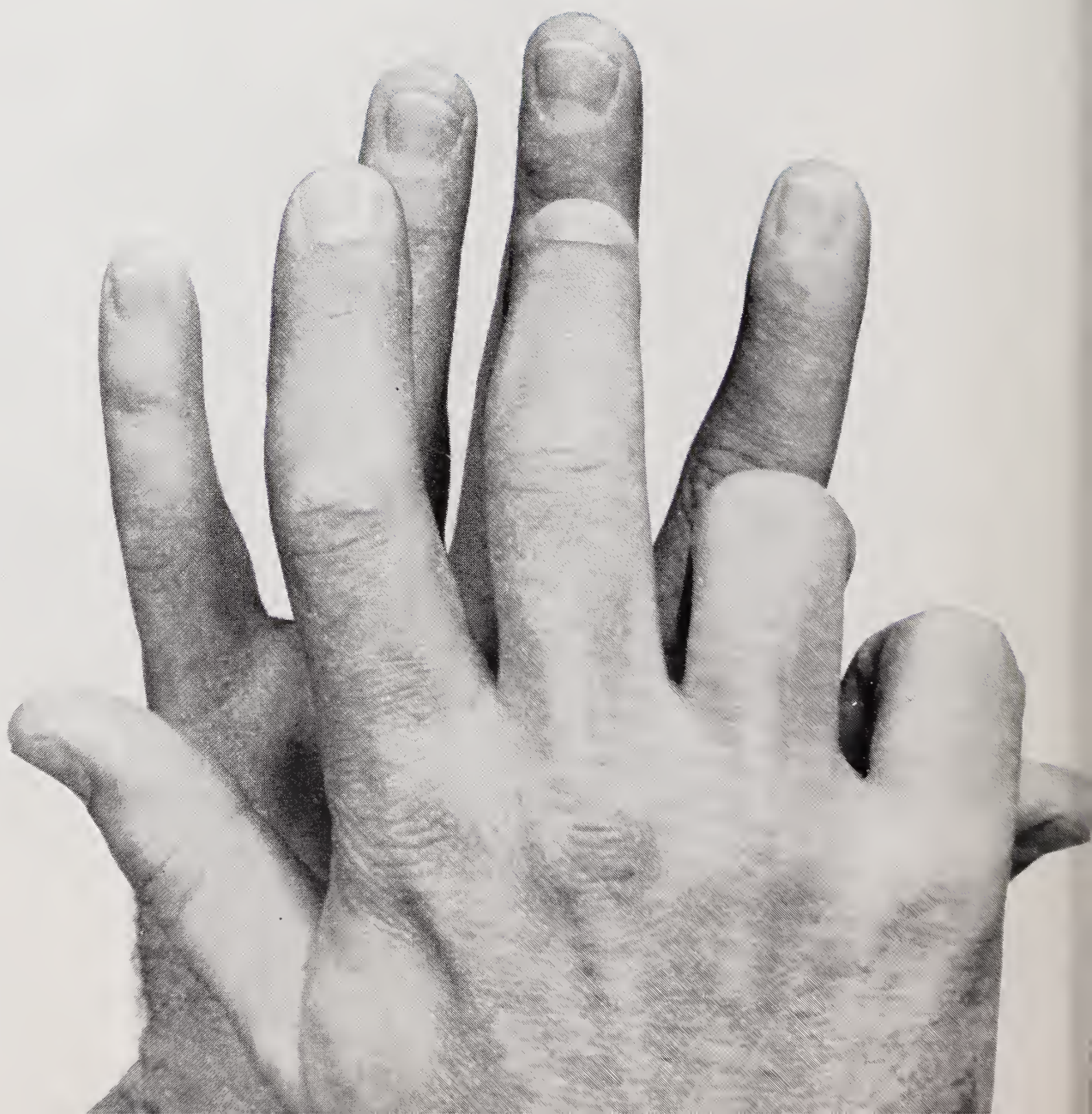
See page 79

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Contents

Scientific Articles

OPTIMAL AGES FOR ELECTIVE SURGICAL PROCEDURES IN INFANTS Hugh B. Lynn, M.D.	55
ACUTE IDIOPATHIC PERICARDITIS, A CONTINUING DIAGNOSTIC PROBLEM Major Frederick S. Armstrong, M.C.	58
DEPRESSIONS IN DISGUISE T. A. Watters, M.D.	63
SCOLIOSIS TROUBLE Darius Flinchum, M.D.	67
SCIENTISTS, MECHANICS AND HEALERS Reid Gullatt, M.D.	71
A PLAN FOR CONCERTED ATTACK ON THE STAPHYLOCOCCUS Jack C. Norris, M.D.	74

Editorials

MRS. W. BRUCE SCHAEFER APPOINTED STATE WELFARE DIRECTOR	78
THE TECHNIQUE OF RADIOISOTOPE PHOTOSCANNING.	79
THE MONK STUDY	79

Features

How Well Are We Telling Our Story?	66
Cancer Page	81
Heart Page	82
Legal Page	84
Mental Health Page	86
Abstracts	88

The Association

Deaths	90
Societies	90
Personals	90
Executive Committee of Council Meeting, December 8	91
MAG Council Meeting, December 8	92
Advertising Index	54A

Cover

203

Mercury labeled Neohydrin Brain tumor photoscan from Piedmont Hospital Department of Radiology. Photographic processing courtesy of Mr. John Pfeiffer, Eastman Kodak X-ray Division, Atlanta, Georgia.

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OPTIMAL AGES FOR ELECTIVE SURGICAL PROCEDURES IN INFANTS

Hugh B. Lynn, M.D., *Rochester, Minnesota*

■ ***A heavy burden is placed on the conscience of the pediatric surgeon in doing elective procedures***

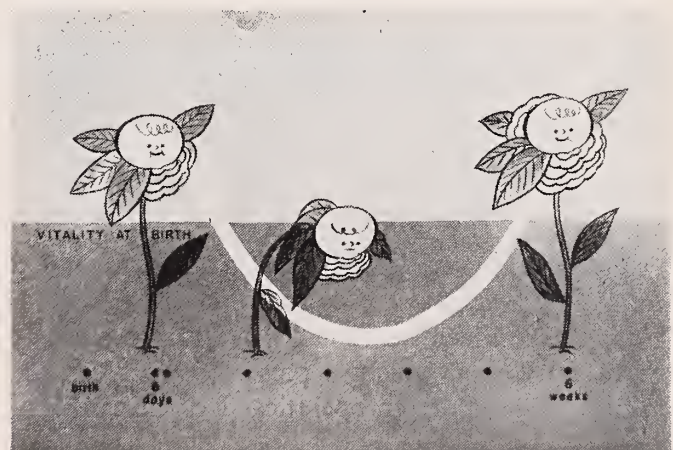
ALTHOUGH EMERGENCY situations obviously must be dealt with as they occur, most conditions requiring surgical intervention in infancy are of an elective nature and permit orderly study, preparation, and operation under the most propitious circumstances. Unfortunately, many physicians are unaware or uncertain of some of the elective procedures. As a result of this dilemma, some urgent conditions may be unduly delayed and other less pressing conditions treated as impending catastrophies.

Every condition and individual case which is remediable by operation must be considered on its own merits. The nature of the lesion and the condition of the patient are of utmost importance. The emotional make-up of the parents and personal circumstances (geographic location, finances, and care of other siblings) cannot help but influence somewhat the total evaluation, and this must be the problem of the family physician and the surgeon.

One should be ever mindful of the mysterious vigor and vitality of the newborn infant. Although there is little documentation from the laboratory, it is well accepted among surgeons and anesthesiologists dealing with infants that the newborn baby is better able to withstand long, debilitating surgery during the first few days of life than at any time during the next five to six weeks (Figure). Naturally this stamina varies from patient to patient but is a factor which must be considered at all times.

An important corollary is the fact that, while the tiny infant tolerates one shocking procedure surprisingly well, a second major insult all too frequently ends fatally. For this reason the newborn's reserve and vitality should be jealously guarded for the emergency condition and not squandered on a purely elective procedure.

Any set of rules for optimal time of surgical intervention must be based on many factors, all of which will vary with the circumstances. The routine elective procedure on an infant at a large medical center may well be a case for operation at a much older age in a rural community hospital. The variables of facilities (laboratories, blood bank and incubators) nurses, anesthesiologists, and qualified surgeons, all must be considered before advising parents of the



Figure

A pediatric surgeon's impression of the vitality of the newborn infant.

decision to perform an operation. The ages for surgery expressed must reflect the circumstances in which the surgeon practices.

Surgical Lesions

Inguinal Hernia

Whenever a diagnosis of inguinal hernia is made on a healthy infant or child, operation should be advised provided the patient is six weeks of age and showing a definite gain in weight. Bouts of incarceration or failure of a premature infant to thrive may lead to surgical intervention at an earlier age if necessary. An infant rarely requires an operation during an episode of incarceration. Every effort should be made to reduce the hernia by gentle pressure with the patient sedated and in a head-down position. In the rare instances in which this is not effective, general anesthesia may be necessary. Occasionally an already exhausted infant can be returned from the operating room after anesthetization but spared the actual operation. He is then able to return to the operating room 48 hours later rested, well-hydrated, and with less edematous and inflamed tissues.

Umbilical Hernia

Surgical intervention for umbilical hernia is a most debatable issue. Certainly most of these herniations will close spontaneously without any care whatsoever. It has long been my practice to advise strapping during the first three months of life, for the strapping may help prevent enlargement of the subcutaneous pouch and thus reduce the handicap that nature is attempting to overcome.

With the exception of unusually large and symptomatic hernias that occasionally require surgical measures within the first year, it seems wise to postpone these procedures into the second year of life. Incarceration is rare, and observation rarely, if ever, endangers the patient.

Undescended Testis

Concepts of this condition have changed in the past few years, and opinion has gradually swung toward earlier surgical correction. Although the significance of the biopsy findings is not yet fully apparent, it is evident that histologic changes take place in the undescended testis between the ages of five and seven years.¹

In view of this fact, when at all possible, the testis should be dissected free and placed in the scrotum before the child enters school (five to six years of age). The hernia, which is present 99 per cent of the time, will require an operation. No one can deny that this part of the surgical procedure cannot be avoided by use of hormones even in the case of questionably undescended testis.

The major problem is to separate the really undescended testis from the "bashful testis" whose cremaster muscle is able to draw it up into the external ring to protect it from exposure to cold hands and critical eyes. Early operation is performed for the true undescended testis for several reasons:

1. The final result is more likely to be satisfactory and the procedure more easily tolerated at an early age.
2. Psychologically all little boys want to be alike.
3. The hernia must be corrected at some time, and incarceration or strangulation can thus be avoided.
4. The added hazard of trauma to a gonad which is trapped in a fairly rigid area is avoided by early operation and the actual presence of a testis is verified.
5. The possible malignancy of the testis will be detected at an earlier stage.

Thyroglossal Duct Cysts

The hazard of any cystic mass is the possibility that it may become infected or that it may represent a malignant lesion. Once the diagnosis is made, surgical intervention should be offered if the patient is physically ready and is beyond the first six weeks of life.

Branchial Cleft Cysts, Sinuses, and Dimples

Here again the hazard is infection with burrowing sinuses. Surgical measures should be recommended as for thyroglossal duct cysts and the first branchial cleft lesions (pre-auricular) should be as urgently pursued as the second cleft lesions in the neck anterior to the sternocleidomastoid muscle.

Cystic Hygromas

Obviously surgeons would prefer to treat these in the same way as the umbilical hernias—by watchful waiting. Unfortunately, all too frequently these lesions grow rapidly and may cause respiratory distress and an even more difficult dissection as a result of waiting. While this must be an individual decision arrived at after intelligent discussion with the parents, I make every effort to allow the patient to reach six months of age before attempting an extensive dissection.

Pilonidal Cysts, Sinuses and Dimples

While these do not frequently cause difficulty in infancy, the miserable results of neglect in the older age groups cannot help but influence the conscientious (or cowardly) surgeon to advise an operation any time after six months of age. This type of lesion can often be removed at the time of operation for inguinal hernia, or a similar procedure.

Hemangiomas

Many physicians do not consider hemangiomas a surgical problem. Port-wine stains are almost never treated surgically. The umbilicated strawberry type of cavernous hemangioma has received great attention in the medical literature. It is true that the majority of these are self-limited and are rarely encoun-

tered in adult practice. However, no criteria have been established to judge the lesions which will persist, grow, and disfigure. The difficulty is that, after months of inactivity, these hemangiomas may grow with amazing rapidity and spread to areas where achieving an acceptable surgical result is impossible. For this reason surgeons have little enthusiasm for lesions in areas such as the face, axilla and arms. Every effort is made to take advantage of hospitalization and anesthesia for other reasons when excising these hemangiomas. When spread would produce an unsightly surgical result, early surgical intervention is urged.

Cleft Lip

The urgency in spirited these infants from the delivery room to the operating table is now being recognized as an attempt to spare the parents feelings. Certainly there is no emergency in so far as the patient is concerned. Much may be lost if the infant's resources and vigor are expended in the immediate newborn period in this surgical procedure, only to find that the infant is also suffering from intestinal atresia or some other anomaly incompatible with life. Once the baby has learned to handle his feeding problem, has passed the first six weeks of life, and has shown an adequate steady gain in weight, elective surgery is indicated.

Cleft Palate

In spite of all the arguments for delaying operation until maximal growth of the maxilla has taken place and for using prostheses, the basic problem appears to be the fact that the majority of these children establish lasting speech habits by two years of age. These habits defy the average household unless blessed with gifted parents, speech therapists or other aid. An operative procedure which shows proper regard for the blood supply in this region and avoids trauma to the body structure when the child is between 14 and 18 months of age gives satisfactory

results. The larger the oral cavity, the easier the procedure, but the older the child the more tendency to attempt to occlude the nasopharynx by compressing the nostrils.

Pectus Excavatum

Each year I see an increasing number of these cases in consultation and operate on fewer and fewer of them. There seems to be no justification for operation in the infant age group. It is probably wise to follow them at six-month intervals, withholding any decision until after the child is three years of age. From this time on, the more severe and disturbing cases will gradually come to operation. It seems sensible to make final disposition of the others before the boys enter school, between five and six years of age. Although an occasional female will require surgical treatment, this is usually a problem confined to the preschool male.

Comment

Elective surgery places a heavy burden on the conscience of the pediatric surgeon. The procedures usually are not technically difficult, and the response of the child is admirable. The burden lies in the fact that many emergencies are mainly in the minds of the parents. Their concern and anxiety are understandable but are rarely sufficient reason for the performance of an elective procedure under emergency circumstances.

When the general physical examination shows that the patient is in the best condition to be anticipated, when the hospital facilities are optimum and the anesthesiology at top caliber, then the surgeon may look the parent in the eye and advise an elective operation.

Mayo Clinic

Reference

1. Robinson, J. N., and Engle, E. T.: Some Observations of the Cryptorchid Testis, *J. Urol.*, 71:726 (June) 1954.

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ACUTE IDIOPATHIC PERICARDITIS

A Continuing Diagnostic Problem

Major Frederick S. Armstrong, M.C., *San Jose, California*

- ***Despite our increasing diagnostic aids, we still fail to recognize the presence of pericarditis in a fair percentage of cases.***

ESTABLISHING AN ACCURATE diagnosis in acute pericarditis is important, not primarily because of its morbidity or mortality, but because it can mimic other diseases of the chest such as spontaneous pneumothorax, pulmonary embolism, pneumonitis, dissection of the aorta and, especially, myocardial infarction. Despite considerable interest and research in this subject during the past several years, acute pericarditis remains a continuing diagnostic problem. As recently as 1958 Sodeman and Smith noted a diagnostic accuracy on admission of only 20 per cent in a group of 40 patients with acute pericarditis.¹ Not only is its presence difficult to establish, but the cause is often obscure and the complications not fully appreciated. After having experience with several cases during the past few years we are impressed with the continuing difficulty in accurately evaluating each new case of acute pericarditis or conditions with similar manifestations. To illustrate our thesis we will discuss acute pericarditis in light of the specific diagnostic problems it presents.

Case One

J. J., a 9-year-old Caucasian male, had mild upper respiratory symptoms including cough, intermittent fever, and malaise for three weeks prior to admission. For one week prior to admission he experienced recurrent constricting substernal chest pain aggravated by coughing, deep breathing, and body movements. No pericardial friction rub or murmur was audible

and his lungs were clear to percussion and auscultation. LE prep, antistreptolysin titer, chest X-ray, and skin tests for coccidioidomycosis and histoplasmosis were negative. Tuberculin skin test was positive and a few atypical lymphocytes were seen on the peripheral blood smear. The initial electrocardiogram demonstrated elevated ST segments in leads II, III, AVF, and V₂ through V₆ (Figure 1). The patient's symptoms promptly subsided after admission and, except for transient left pleuritic pain and a pleural friction rub on the fourth hospital day, his course was uneventful and his recovery complete. Serial electrocardiograms evolved a fairly typical pattern of acute pericarditis (Figure 1).

This patient, then, represents a fairly typical case of acute idiopathic pericarditis with fever, upper respiratory symptoms, and substernal chest pain, aggravated by breathing and recumbency, supporting electrocardiographic evidence of pericarditis, and complete recovery.

Case Two

T. R., a 20-year-old Caucasian male, on admission appeared as a typical case of acute idiopathic pericarditis with a nine day history of fever, cough, chest pain aggravated by breathing and recumbency, a pericardial friction rub and ST segment elevations in most leads of his electrocardiogram (Figure 2). However, on his second hospital day he became severely dyspneic, heart rate increased to 120, pulse pressure narrowed and a paradoxical pulse of 20 mm by sphygmomanometer determination developed. Chest X-ray at this time revealed a large cardiac

¹Presented at the 108th Annual Session of the Medical Association of Georgia, May 7, 1962, Savannah, Georgia.

silhouette and an infiltration in the right lower lobe (Figure 3a). Believing that cardiac tampanade had developed, a pericardicentesis was performed and 100 ml of sanguinous fluid was aspirated. Immediately after the pericardial fluid was removed the patient's dyspnea diminished, heart rate dropped to 80, and the paradoxical pulse disappeared. The remainder of his hospital course was uneventful and he progressed to complete recovery (Figures 2 and 3b). No specific etiology was discovered but his course was most consistent with viral pericarditis.

In this case the diagnostic problem was not in establishing the presence of pericarditis but in determining whether or not cardiac tampanade was present. Although not a common complication of acute idiopathic pericarditis, tampanade is extremely important and prompt recognition and treatment can be lifesaving.

Case Three

R. B., a 52-year-old Caucasian male, was admitted to the hospital seven hours after the sudden onset of severe substernal constricting pain, shortness of breath, and sweating. Temperature was normal and no pericardial or pleural friction rubs were audible. The admitting diagnosis was acute myocardial infarction. The electrocardiogram on admission demonstrated marked elevation of ST segments with upward concavity in most leads (Figure 4). Daily serum transaminase levels were normal and serial electrocardiograms demonstrated the evolution of a pattern typical of pericarditis (Figure 4). No etiology for this pericarditis was discovered and the patient recovered completely.

In this case we wish to emphasize the patient's age, 52, which is older than most cases; his sudden onset of severe substernal pain; and the marked ST segment elevations in the electrocardiograms. This is the type of case which is most frequently mistaken for acute myocardial infarction.

Case Four

W. W., a 35-year-old Caucasian male, experienced intermittent constricting substernal pain for one week prior to admission. Except for the electrocardiogram (Figure 5) initial studies were negative. The diagnostic impression at this time was acute myocardial infarction and he was started on anticoagulant therapy. However, when serial transaminases were normal and no definite QRS changes developed, we began wondering if he might not have pericarditis, for if he had pericarditis, he should not be on anticoagulant therapy. Definite QRS changes indicative of infarction did not develop until the 23rd hospital day (Figure 5). Although on admission there was electrocardiographic evidence of infarction, such as

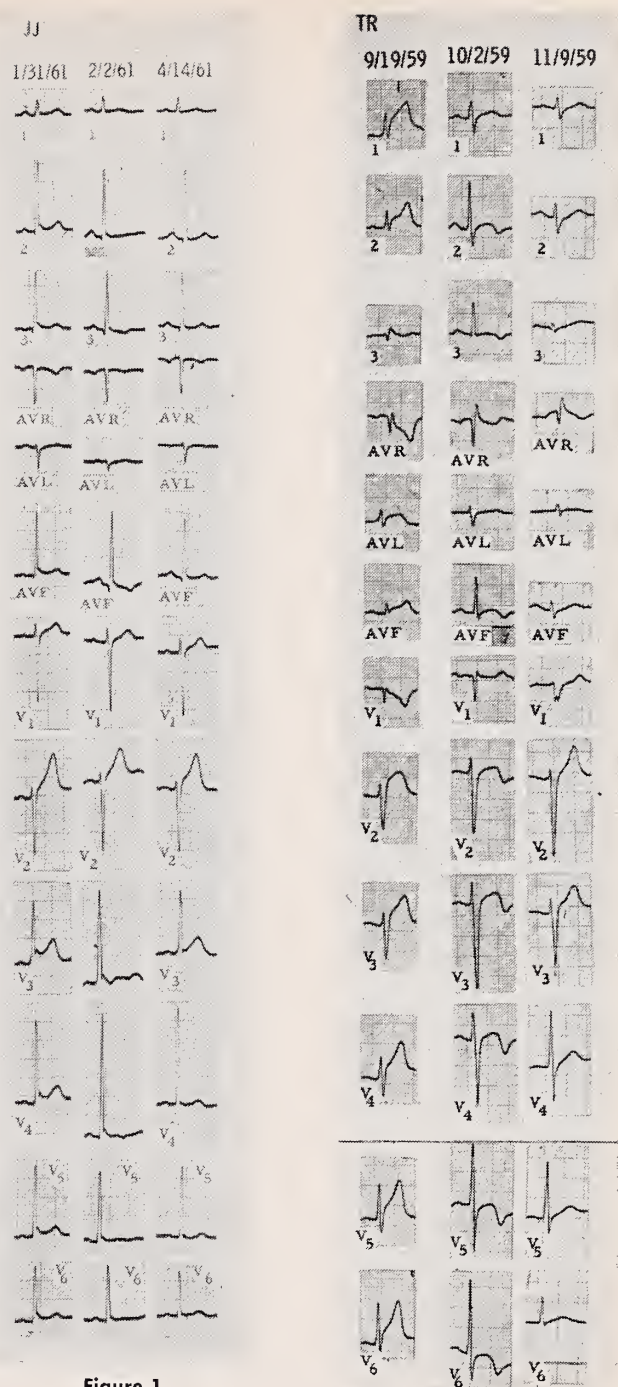


Figure 1
J.J. Case Number One
January 1, 1961—
Day of Admission
April 14, 1961—
After Complete Recovery

Figure 2
T.R. Case Number Two
September 19, 1959—
Day of Admission
November 9, 1959—
After Complete Recovery

the low R waves in V₃, the lack of reciprocal ST segment and QRS changes plus normal serum transaminases caused us to seriously consider acute pericarditis for several days. The patient may have had pericarditis as part of his acute myocardial infarction.

Even though this case was not unlike other cases of acute myocardial infarction seen by many physicians, we present him to illustrate that differentiating pericarditis and myocardial infarction during the acute stage is often difficult and whereas anti-

coagulant therapy is generally indicated for one, it is contraindicated in the other. Furthermore, the prognosis of the two conditions is quite different.

Discussion

For many decades establishing the presence of pericarditis regardless of cause has been a continuing problem. Despite our increasing diagnostic acumen through improved electrocardiographic techniques and a growing awareness of this condition, we probably still fail to recognize the presence of pericarditis in a fair percentage of cases. When a young patient presents with fever, constricting substernal pain aggravated by breathing, swallowing, or lying down, and electrocardiographic changes typical of subepicardial ischemia—all very classical findings—the diagnosis seems fairly simple. However, if the pain is strictly pleural in character, as is often the case, and if the chest X-ray demonstrates an infiltration in the lower lung fields, atypical pneumonitis is all too evident and the possible presence of pericarditis is easily overlooked. Or if a middle-aged patient presents with severe substernal constricting pain and has elevated ST segments and/or T wave inversions in various leads in the electrocardiogram, acute myocardial infarction often seems obvious, the patient is placed at absolute bed rest and anticoagulant therapy is begun. Acute pericarditis can also mimic the acute surgical abdomen with pain referred to the epigastrium and abdominal rigidity. The more

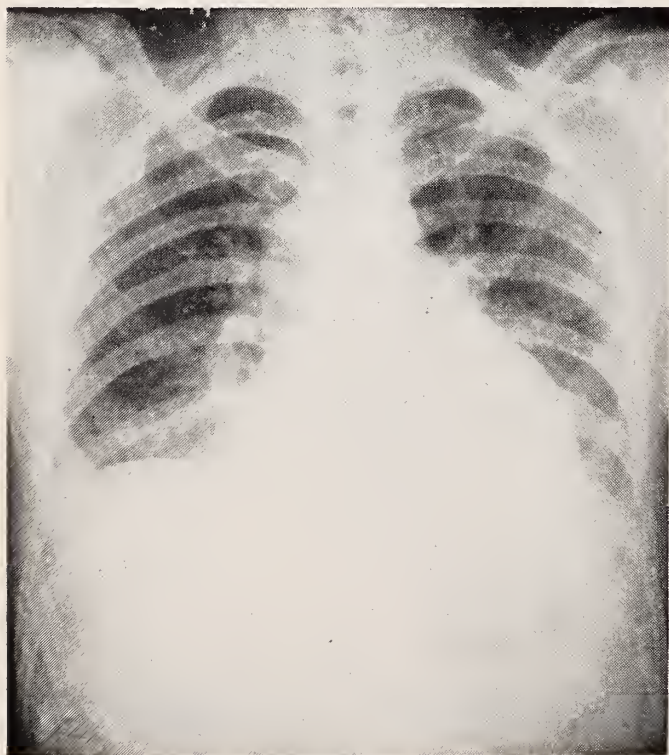


Figure 3a
Second Hospital Day

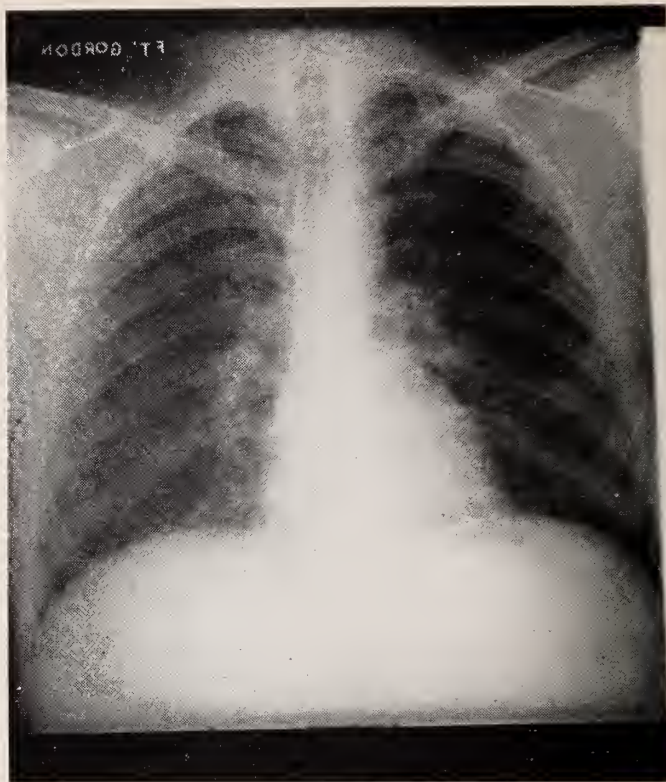


Figure 3b
After Complete Recovery

pathognomonic findings such as pericardial friction sounds, typical electrocardiographic abnormalities, and X-ray evidence of pericardial effusion are often absent, but if one thinks of pericarditis in these less typical cases, the diagnosis will be made more often.

The continuing diagnostic problem concerns not only the presence of pericarditis but also the cause. Recent studies have indicated that many cases of acute pericarditis, previously labeled idiopathic, are caused by viruses such as Coxsackie,²⁻⁹ influenza^{10,11} chickenpox¹², infectious mononucleosis¹³⁻¹⁸ and lymphogranuloma venereum¹⁹. Of these viruses the Coxsackie, especially group B, seems to be most common. Acute pericarditis can also be a manifestation of hypersensitivity states, such as serum sickness²⁰⁻²², asthma²³, and allergic granulomatosis²⁴. If the manifestations of pericarditis dominate the clinical picture, the basic hypersensitivity condition can easily be overlooked. This situation can also occur with pericarditis in collagen diseases such as rheumatic fever, rheumatoid arthritis, disseminated lupus erythematosus, and periarteritis. Other conditions which can cause acute pericarditis are listed in Table I. Note that the term "idiopathic" has not been included in this table since it is not a specific entity and will probably be used less often as better diagnostic aids, especially viral studies, are developed and become more readily available. Because of its frequency, acute tuberculous pericarditis is especially important. The systemic mycoses such as coccidioidomycosis and actinomycosis rarely cause acute pericarditis and are usually only a part of more widespread in-

volvement. The parasitic conditions which include hookworm, amebiasis, and echinococcosis, also quite rare, may cause pericarditis by direct involvement by the infecting organism, or possibly through an immune mechanism. The remaining causes should seldom be difficult to recognize.

A third continuing diagnostic problem in acute pericarditis is recognizing the complications. Cardiac tampanade is especially important and occurs most often in cases given anticoagulant therapy because of a mistaken diagnosis of myocardial infarction. Arrhythmias, including ventricular tachycardia²⁵, premature atrial and ventricular contractions, and a shifting pacemaker²⁶, have been reported but are extremely rare. Chronic constrictive pericarditis,^{27,28}, not related to our thesis and mentioned only because of interest, is another important complication.

Summary

In summary, we have stated that acute idiopathic, or non-specific, pericarditis is a continuing diagnostic problem in three respects. First, because of its clinical similarity to many other conditions of the

Table I.
Causes of Acute Pericarditis

- A. Infections

 1. Viral—Coxsackie, influenza, chicken-pox, infectious mononucleosis, hympho-granuloma venereum.
 2. Bacterial—tuberculosis, pyogenic or-ganisms, syphilis
 3. Fungal—coccidioidomycosis and acti-nomycosis
 4. Parasitic—hookworm, amebiasis, and echinococcosis
- B. Hypersensitivity states

 1. Serum sickness
 2. Allergic granulomatosis
 3. Asthma and related allergic conditions
- C. Collagen diseases

 1. Rheumatic fever
 2. Rheumatoid arthritis
 3. Ankylosing spondylitis
 4. Disseminated lupus erythematosus
 5. Periarteritis
 6. Scleroderma
 7. Dermatomyositis
- D. Inflammation of contiguous structures
- E. Neoplasia
- F. Uremia
- G. Acute myocardial infarction
- H. Traumatic — direct and indirect

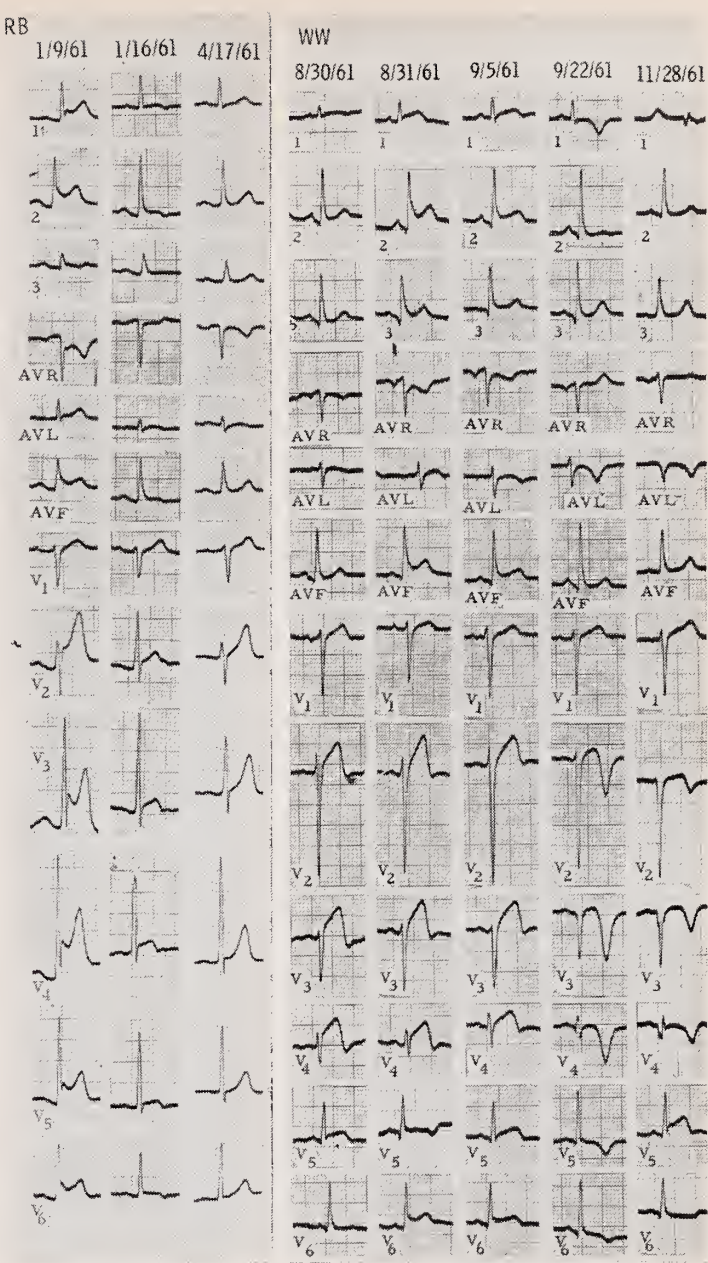


Figure 4

R.B. Case Number Three

January 9, 1961—

Day of Admission

April 17, 1961—

After Complete Recovery

Figure 5

W.W. Case Number Four

August 30, 1961—Day of Admission

August 31 and September 5, 1961—

No QRS Changes from Admission ECG

September 22, 1961—First Day with Definite

QRS Changes of Infarction

November 28, 1961—Follow Up ECG

chest, its presence is often difficult to establish. Second, discovering the cause, which is becoming more feasible with new discoveries and better diagnostic aids, presents a real challenge and should result in less frequent use of the term "idiopathic." And third, the complications such as tampanade, rarely arrhythmias, and chronic constrictive pericarditis must be recognized and treated.

5150 Graves Avenue

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COUNTY MEDICAL SOCIETY OFFICERS CONVENE MARCH 2-3 IN ATLANTA

Projects and programs on "Youth Fitness" and "Politics and Medicine" will highlight the 5th Annual County Medical Society Officers Conference to be convened March 2-3, 1962. This annual meeting, held in Atlanta, is sponsored by the Medical Association of Georgia for leaders of the profession throughout the state.

Youth Fitness Emphasized

The Saturday afternoon March 2 session is devoted to initiating County Society activity in the field of youth fitness programs. Nationally known speakers such as "Bud" Wilkinson, Athletic Director at the University of Oklahoma and Special Consultant to The President on Youth Fitness—and "Duffy" Dougherty, Head Coach at Michigan State University, headline the meeting. Oliver Hunnicutt of LaGrange, Maxie Baughn of the Philadelphia Eagles and Atlanta, Cobern Kelley of Athens, Dick Lane of East Point and others will speak in a panel presentation designed to illustrate how to provide leadership in your community for a local youth fitness program.

The Saturday meeting will convene at the Dinkler

Plaza Hotel and will be followed by the Association's traditional Social Hour for physicians and their wives. This Social Hour features entertainment, fellowship and fun.

Politics and Medicine is the subject of the Sunday morning March 3 session which will be held at the MAG Headquarters Office Building. Dr. Durward Hall, Member of Congress from Missouri, will keynote the meeting with the AMA's Field Service Director, Mr. Aubrey Gates, advising on ways and means in legislative issues. Outstanding AMPAC (American Medical Political Action Committee) and GaMPAC, speakers will discuss political activity past, present and future.

"Be With MAG"

County Society Presidents, Secretaries, Public Relations Chairmen, Legislative Chairmen, et al., are being invited to, "be with MAG on March 2-3." Any MAG member wishing to attend this Conference is welcome. Programs, Hotel Accommodation Reservations and other Conference data may be obtained by writing the Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta 9, Georgia.

DEPRESSIONS IN DISGUISE

T. A. Watters, M.D., *Metairie, Louisiana*

■ ***This symptom complex may occur in association with any disorder.***

MOST EVERYONE at some time in his life has experienced a depressive flurry. Thus, most in this audience have felt the effects of this mood. Further, a large number have had suicidal thoughts, others homicidal as well as suicidal thoughts, and still other fears along with the thoughts.

Family physicians who cultivate the skills of looking, observing, listening, hearing, and inferring can foresee and use these means with respect to pre-symptomatic conditions of his patients' early environment. These skills can also be useful in detecting disappointments, deprivations, frustrations, abuses, and seductions, and to help ameliorate their effects as fateful determinants for future difficulties.

A Comparison

Linn compares depression to anxiety in that it is a symptom complex that can be associated with any disorder.¹ Its manifestations can be found associated with normal mourning over a spectrum that comprehends schizophrenic reactions with depressive features.

A depressive mood may be similar to hypothermia in so far as it is characterized by its diffusiveness and lowering of function so that the whole person is affected physiologically, psychologically, and sociologically, and generally, if there is a family history of depressions, or the patient has had one before, severity of his first depressive experience may set the pattern for his future.

Always there is some anger and feelings of guilt, but the anger is turned inward or reflected upon oneself. As a rule, also, a diminution of self esteem

evolves resulting from the strong need for help, actuated by a fear of helplessness that compromises one's estimation of self sufficiency. In some cases there may be agitation comprising a vital effort to re-establish one's relationship with his environment, or in another case, there may be phases of mania which are flights of victory over one's conflicted struggles.

A classical description of a depressive reaction requiring forthright attention would be:

Physiologically: insomnia, especially characterized by early morning awakening; loss of appetite and dryness of the mouth; loss of weight; constipation; amenorrhea; impotence.

Psychologically: mood lowered, sad, melancholic; activity reduced; thought retarded; speech slowed to a monotonous flow; self-incrimination, hinting guilt, anger, and a need for punishment; self-depreciation; suicidal preoccupations and possible perpetration; homicidal thoughts, sometimes in reference to spouse, other times inclusive of family; loss of capacity to love; hypochondrical trends or even delusions.

The Sociological Viewpoint

Sociologically: loss of interests in work, family, and friends. Although classic syndromes and clinically psychotic depressions are on the decrease, and fewer go to and constitute any great percentage of state hospital residents, at the same time, there are more depressive reactions less dramatic, but nonetheless often more fickle, that are seen in general hospitals, clinics, and by general physicians. Many depressive reactions are disguised, but potentially the patient may be on the verge of taking action due

¹Presented at the 108th Annual Session of the Medical Association of Georgia, May 7, 1962, Savannah, Georgia.

to his suffering when tensions mount and conditions become acute. In fact, the desperation and negative outlook may point up more readily than the depressive mood. This is more apparent in patients seen by the psychiatrist today as he listens to verbal productions veiling unhealthy attitudes and outlooks which clothe despondency, futility, and fear of losing one's identity.

What are some of the disguises of depression?

One may encounter organic illness or disorder under such conditions as: influenza, especially following the acute phase; conditions alleged to be "influenza" which can be short lived depressive bouts; hepatitis, following the acute period; undulant fever; tuberculosis; syphilis; poliomyelitis; organic brain or spinal disorders; malignancy; burns; amputations; abdominal operations, more so if the patient is female and conceives it as a threat to her feminine integrity and function; genito-urinary surgery, particularly if there has been any assault upon one's sexual potential; cataracts; removal of an eye.

Psychologic Pattern

Another disguise for a depression is psychologically patterned such as: the gloomy, pessimistic person; the hostile, spiteful makeup; the overly optimistic, buoyant person who is acting under pretense; the person who is successful in spite of himself, who might be intensely fearful of poverty and helplessness; the person always working because he is fearful of his fantasies of being alone, without friends, without love, and being insignificant; the person who blames himself with regard to income-tax reporting, and having dreads of exposure, which very often may not be the true nature of his problem, he uses this means of reproaching himself for underlying guilt feelings and depression; the person who is self-blaming, and in the case where there is an associated pain syndrome, will not respond to a therapeutic program; the person who is preoccupied with death and has arranged his business affairs, made his will, revised his insurance policies; the person who demonstrates phases of interest in attending church and religious activities, seeking help and meaning for existence, may thereby be concealing guilt feelings, and tenuous attachments of reality. The last three examples can be serious suicidal risks.

Physiologic Disguise

A third disguise may be physiologically related to a depression such as: gastro-intestinal complaints; when anorexia is prolonged; when there is sudden change, but continuous thereafter, in eating habits;

indigestion that is prolonged; cycles of food aversion, primarily to solid food, and accompanied by severe loss of weight, with or without partaking of alcohol; anemias that cycle; genito-urinary system; amenorrhea; erratic menstruation with or without dysmenorrhea; following surgery, perhaps a hysterectomy, when the body image is disrupted, thereby affecting confidence in attracting, stimulating, and holding one's mate; impotence in the male if surgery on himself or his mate mobilizes conflicts; insistence on separate bedrooms because one spouse allegedly is being disturbed by the other's snoring. As a prerequisite, the spouse who is annoyed by the snoring may have hostile feelings and associate this noise with the final stages of death. In other words, the spouse is, in reality, indulging in murder fantasies. Insomnia or intermittent sleep, therefore, may be explained in terms of these hostile notions; sleeping during the day which may be a retreat from boredom, or a depressive equivalent; fatigue, when it results from light effort; depletion syndromes, sometimes with striking symptoms if the inner self is devoid of self-esteem. Carbohydrate metabolism may offer important clues for complimentary therapy because often there are daily energy cycles; thermal response patterns of sensitivity to both heat and cold, but more likely a response to cold, particularly if it is a persistent complaint; eye syndromes which may be frequently associated with disguise, because the eyes serve as an elegant media for non-verbal communication.

Emotional Life

This is true in respect to the emotional life, wherein these organs are so sensitive to excursions and vagaries of mood, and in relationships play a great role in reciprocal understanding. The eyes themselves may be perceived by an observer as being blurred. But, they may actually perceive an object in terms of blurredness. It is this blurring that brings the person to the ophthalmologist around middle life for hopeful adjustment of glasses with an actual optical change, also, that is consonant with this period of life. In either case, lurking behind this blurredness may be symptoms of a depression. In the case of the person needing new prescriptions for his glasses, this simply may be the result of the mid-life change, or it indeed may be a means of shielding a depressive condition, if the blurring also applies to interests, and activities, as well as objects. If this is true, then the overall feeling of distance and absence of zest for human participation is present, too; skin syndromes that offer a depression a hiding place, however, they may not respond to treatment until the depression itself is treated. A depression under such circumstances may not be recognized, because the doctor

may think it is the result of the skin disorder and, therefore, not treat it as a primary condition. Consequently, one sees a rationale in treating the person as a whole. Because of a fragmentary approach, with limited use of healing skills, the problem of dermatological disorders may remain unsolved for the simple reason these dermatoses are depressive equivalents. The skin is an organ of exhibition which responds to touch, warmth, and rubbing all of which may have infinite connotations. Further, this organ is a target for hostility that one may use as a means of fulfilling his need for punishment. Also, one may derive subtle gratification through its use. Headaches, prevailingly annoying, that are present without traditional organic determinants, may be the product of a hostile guilt ridden relationship, when there are crescendos of mounting discomfort that may coincide with the premenstrual period, but which are, in fact, an underlying disguise for a depression. The complaint of "fullness" felt in the head may be associated with progressing, disappointing, and aggravating life situations where there is no relief from increments which can reach such proportions that one may feel head tensions "as though the head will burst." Lurking behind these complaints often lies a strong aggressive and destructive thought associated with what may be at times, painful misgivings; syndromes of hypochondrical preoccupations, complaints, and approximating delusions.

Fourth Disguise

A fourth disguise for a depression may be manifested sociologically such as: the restless, irrepresible person with a necessity for constant activity, which can be a distracting evasion of underlying monotony or boredom, but whose contributions to his community may be many; dedication syndromes found in some physicians driven by an unending need for approval from those he cares for, but which leads him to an overloaded program of practice. In order to maintain the pace, he may rely upon stimulants and sedatives. Early retirement or prolonged vacations may be a front for a depression, too. In all, however, the by-product, socially speaking, is worth while devotion and help to his fellow man.

Presymptomatic conditions such as changes in: a family pattern of living; the working milieu; losses of relatives, friends, co-workers, pets, jobs, opportunities, advantages, finances, social position, and lastly, status, may serve as a brewing pot for depressive potentials to evolve.

Additional clues for the physician may be found if the patient relates his visit to a clergyman, which often may be a means of indirectly presenting to the

doctor what he would like to talk about, but when elaborated on may reveal a problem of conscience and depressive manifestations; talks in terms of a third person who is distressed, thereby testing his physician's reaction to what is really his own problem. The patient in reality is probing to find out how his physician, whom he feels only wants to hear about organic complaints, will receive more personal problems of life; gives any recitation of physical complaints indicating that he feels this is the way his doctor requires that he communicate with him, but in truth the patient would like to discuss his "troubles."

Communication A Passport

This communication being the patient's passport, practically all depressions first come to the doctor's attention in this way: any alteration in one's thinking patterns which may be described by a relative as, "his manner of speaking is different," or "he has changed," recalls what Learoyd says. "The stream of consciousness is the most delicate gauge of health, and any disease or poisoning will show itself first in the mode of thought. It is the only way the mind can act in adversity," which Learoyd calls the "first symptom," thus any of these may be first symptoms preceding the more classical ones that follow.² "Do you go to the movies any more?"³ When responses to a question such as this are revealed it may be useful in bringing out material about obscure depressions as: any strong tendency to literal thought or lack of humor followed by asking the patient the meaning of a proverb may assist the physician to identify the underlying presence, not only of depression, but of schizoid disorder as well. A marked difference between an historical account of the illness and the physical survey; a wide discrepancy between causes and complaints; a discrepancy between the patient's story with regard to his home situation, and adverse conditions the doctor sees when he visits it; too frequent visits to the doctor's office when there is a lack of demonstrable reasons; and finally, an unsatisfactory response to appropriate treatment over a reasonable period of time.

Physician Must Remember

The family physician does well to remember that his patient, regardless of the nature of his illness, fears more than anything rejection and helplessness, and this is especially true as far as depressions are concerned, albeit of how the patient recalls, talks, and relates superficially. This will obligate the physician to learn to be mindful of, and apply judiciously, his knowledge of the psychodynamics of a depressed person, and intelligent use of anti-depressant drugs

WATTERS / Continued

in his comprehensive treatment program, remembering that his personality is a powerful principle, often the most useful one he can employ. In such cases where honest consideration tells one his medical limitations have been reached and a more dramatic disorder is obvious, then effective referral tactfully and skillfully made without humiliating the patient is paramount, possibly even with hospitalization and shock treatment. Bear in mind, too, that in depressed

persons, suicide is always a possibility. Thus, the physician should remain a participant in the medical program even though, for a time, the patient may be more directly under psychiatric care.

429 Iona Street

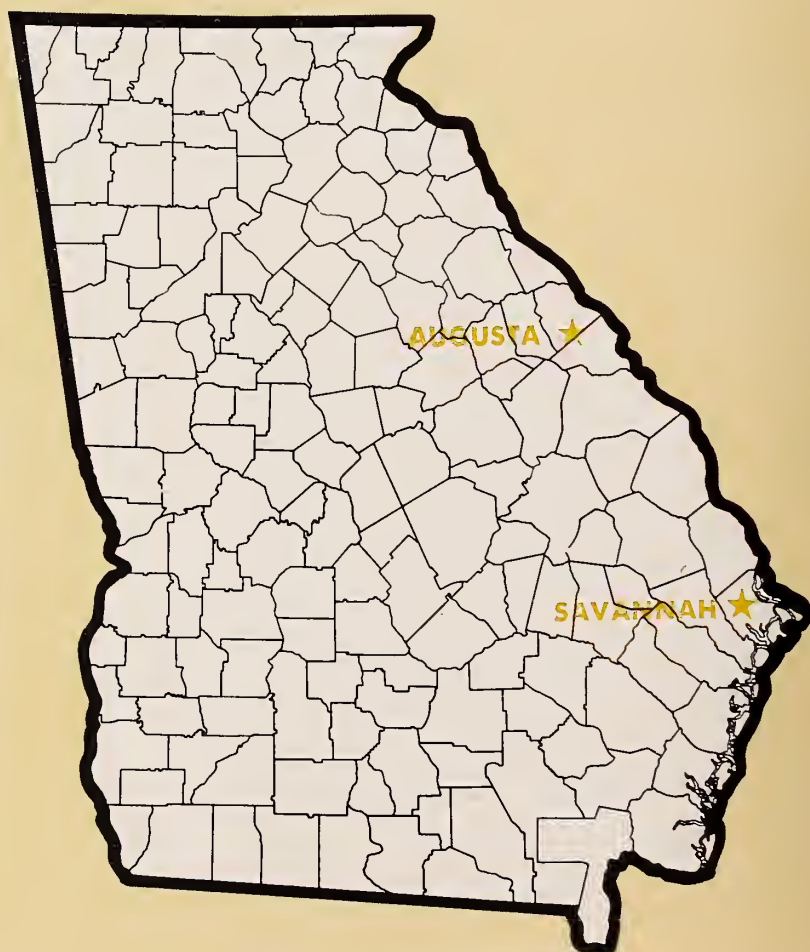
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WHO THE HELL IS GEORGE? Well, he's that mythical fellow who does everyone's work and if anybody knows where he is, have him get in touch. Medicine is in the certain process of having its throat cut and apparently he is the only one willing to do anything about it. If you think this sounds silly, let's just look at the facts.

The two stars on the accompanying map represents the total effort of all Georgia physicians to inform the lay public on any subject, medical or otherwise, during the past 30 days. A well-planned, highly organized effort is being made to sacrifice the profession on the altar of the ballot box and unless we get public support for our position on the "medicare" issue, that is exactly what is going to happen to us. One of the best ideas anybody has had yet is for physicians to make a practice of speaking before lay groups at every opportunity on any subject of interest to the group. In this instance, personal exposure is equal to good public relations and that is what we desperately need.

If we fail to mobilize public opinion in our behalf, the opposition will surely mobilize it to its own advantage. It's our profession, our fight and our future. George can't do it for us.

How well are we telling our story?



SCOLIOSIS TROUBLE

Darius Flinchum, M.D., *Atlanta*

■ ***This age old deformity may now respond to modern methods of treatment.***

IN 400 B. C. Hippocrates described scoliosis and gave it this term, which means lateral deviation of the spine. Actually a rotatory deformity accompanies the lateral deformity. The medical father recommended distraction and counter-pressure. In these 2,000 years the disorder has not changed. It is hoped, however, that most people now have an



Figure 1

This lady, age 26, has now begun having much difficulty getting a support fitted. She also notes fatigue, shortness of breath and pain.

Presented at the 108th Annual Session of the Medical Association of Georgia, May 6, 1962, Savannah, Georgia.



Figure 2

Permanent change is noted in spine and thoracic cage of the patient shown in Figure 1.

awareness for early diagnosis as well as improvement in treatment. It is just uncommon enough in the usual medical practice to allow laxity of vigilance and progression into the hapless tragic end.

Troubles are tests, and scoliosis tests our acumen in early diagnosis and effective treatment. Children in the course of physical examination should be



Figure 5a

On standing, deformity of the spine is evident with the right shoulder low.

made to flex forward, and if any troublesome spine deviation is present, the rotation is quite evident by prominence on the convex side. (Figures 1 and 5b).

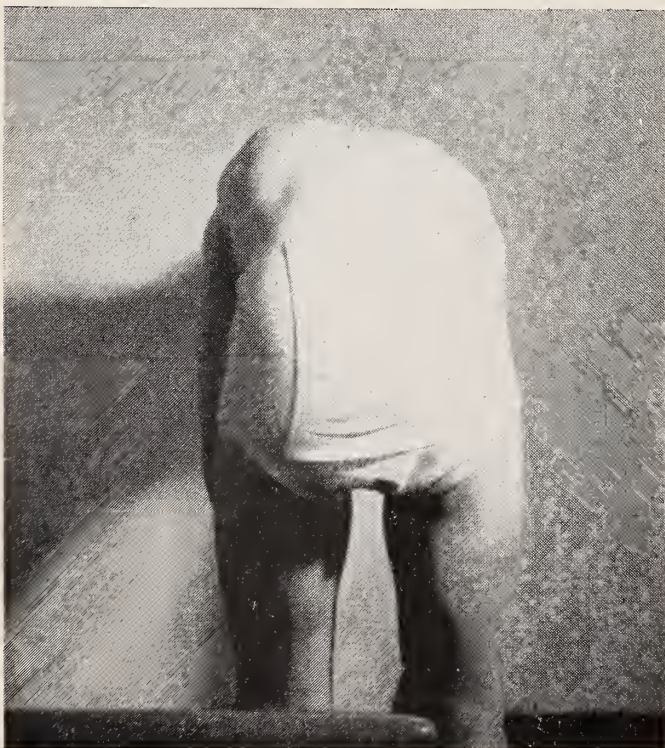


Figure 5b

On bending forward rotation of the spine is noted by prominence on the convex side of the curve.

Etiology, Pathologic Anatomy and Classification

The actual "why" behind the exact mechanism for development of all cases of scoliosis is not always evident. For the most part, muscle imbalance exists. Vertebral deformity with growth change is present either primarily or secondarily.

If the major curve is in the dorsal spine, much chest deformity involving all ribs is present. The ribs, as a matter of fact, with their muscle attachments and pull, form powerful long levers and balancers of the spine. It is important to off-set any existing imbalance here during treatment. The entire spine from the sacrum to the occiput is quite complex with each spine segment having three short levers, which are the spinous and transverse processes along with the associated group muscle attachments. Associated rib cage change allows pulmonary alveolar hypoventilation due to decrease in bellows

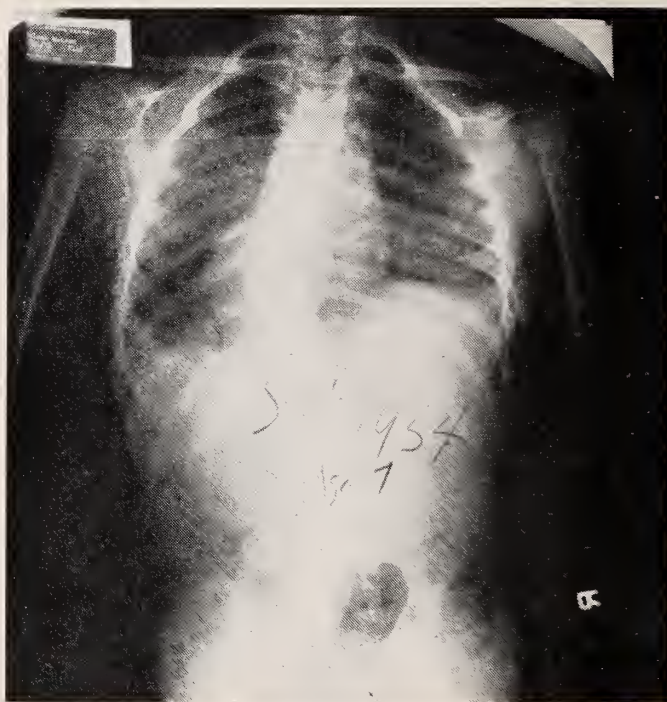


Figure 3

Standing X-ray of a seven year old boy with beginning left dorsal scoliosis.

function. This decrease in vital capacity becomes more marked with age, and in the thirties and forties gives rise secondarily to cor pulmonale and heart failure. For this reason, effective treatment depends on prevention and decrease of the deformity early in childhood and adolescence. Whenever the rib cage starts collapsing, trouble is eminent. On standing X-ray, the ribs on the concave side are noted close together (Figure 4). If the curve goes to the right, as usual, the left anterior chest wall and breast are prominent and the ribs on the right become prominent posteriorly, especially noted on forward bending. (Figures 1 and 5B) The left shoulder is low and one iliac crest may be noted high, which gives some trouble with dress.

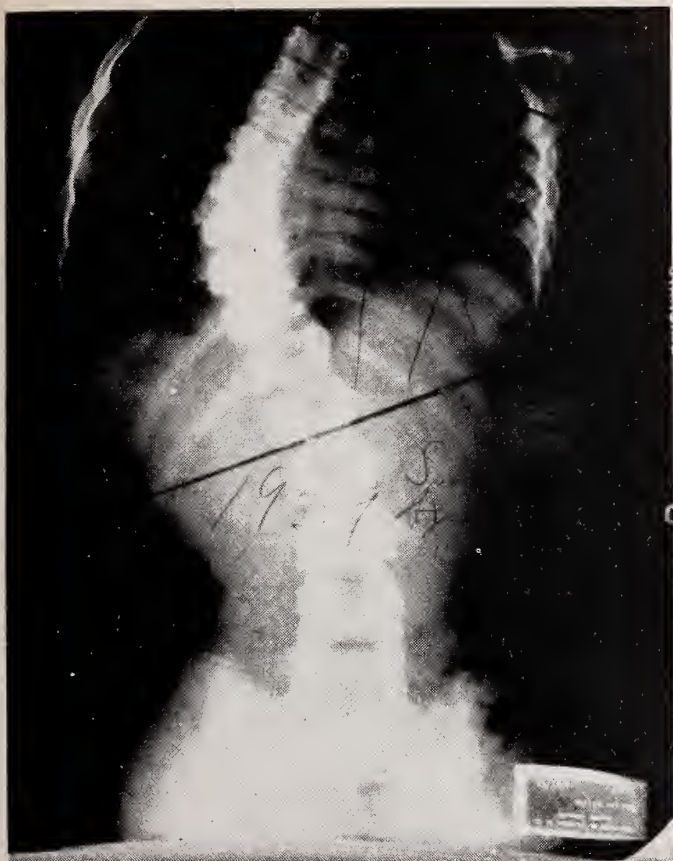


Figure 4

At age 11 much increase is noted with some collapse and elongation of the ribs on the concave side. Left dorsal scoliosis, though less frequent, is more difficult to control in children. Deformity will increase rapidly during the adolescent period.

The most practical classification is perhaps merely functional and structural.

1. Functional scoliosis includes those curves due to postural effect which allows for a changeable deviation.

2. Structural scoliosis indicates a fixed deformity due to congenital vertebral anomaly or deformity, incomplete or partial development of muscle groups, neurofibromatosis, poliomyelitis and any condition causing imbalance of the spine segments.

Nature helps balance the spine by minor or lesser curves above and below the major deviation. By instinct we tend to hold our head over the sacrum and the shoulders and the pelvis with the same frontal plane—*though crooked the world may be, we tend to face it straight.*

Treatment

Proper management depends on the location of the spine deviation along with age and severity. It must be remembered that scoliosis during the growing years does not usually get better but tends to become worse. (Figures 3 and 4). There may be some advancement even in adults. If there is only mild dorsal deviation with one shoulder low and as yet no appreciable rib collapse, swinging by the arm if possible on the low concave side to reverse for a time the leverage pull on the ribs may help some. Deep breathing is important in all people with sco-

liosis in order to facilitate complete alveolar aeration and thus help prevent later secondary emphysema. In lumbar curves and long mild balanced dorsal curves, swinging by both arms is a helpful exercise.

During the young and maturing years a distraction, counter-pressure Milwaukee type brace may be used at night in selective cases as well as for ambulation in an occasional individual. Occasionally postural reversal casts may be of benefit.

Lumbar curves in general do not cause the worry encountered with those in the thoracic region. Fatigue may be a problem necessitating a corset support. Pain due to reactive hypertrophic arthritis in the lumbar spine may be a problem in later years. In severe lumbar deviation it is well to fuse and straighten this portion of the spine during teenage or early adulthood in order to prevent this later complication of mechanical stress arthritis. There is no urgency for correction in this region, however, unless a secondary dorsal collapsing curve develops or, as sometimes happens, a major dorsal curve coexists.

Dorsal spine curves should be treated by operation and correction as soon as chest collapse begins to occur in a growing child, or severe pain, dyspnea and fatigue are noted in early adulthood of those neglected cases. Best results can be obtained in those treated early, and their life span is considerably increased and complete disability in early middle age is averted. (Figures 3 through 7b).

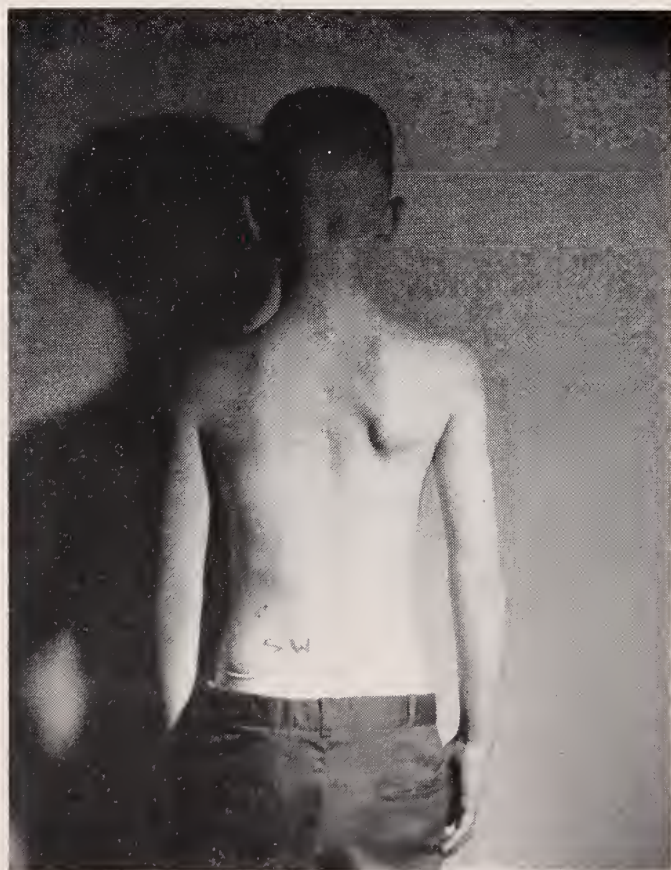


Figure 6

After operation and correction of spine. Note the back is now straight and the shoulders level.

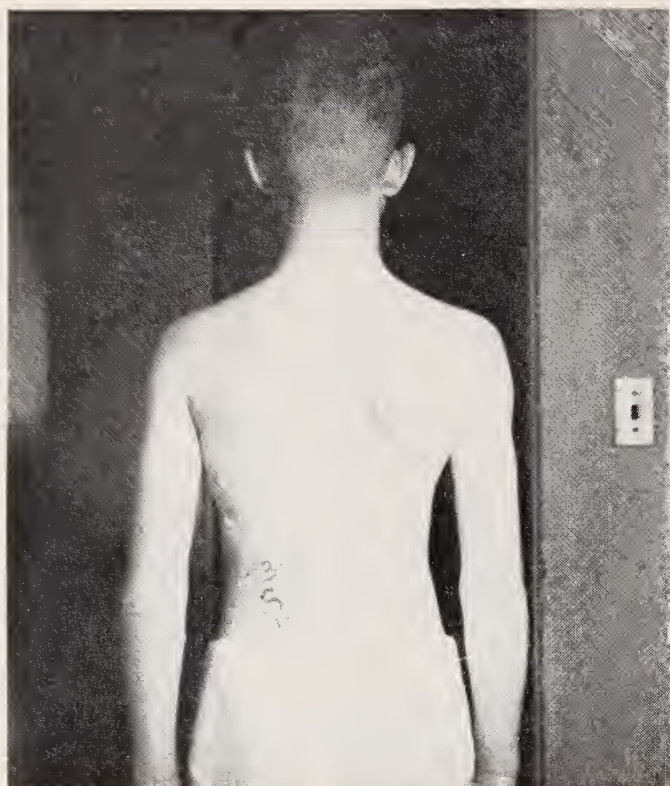


Figure 7a

Three years after operation. The back remains well corrected and he has no restriction in activity.

Operation consists of creating an opposite deforming force by resecting the posterior ribs on the concave side and thus removing the rib leverage and also allowing straightening of the spine. Fusion for permanent holding effect is done of the involved spine at the same time and maximum correction is obtained under anesthesia while applying a holding plaster jacket. Walking is allowed after 10 to 14 days along with the usual routines of activity. No support is needed after one year. These patients have adequate movement of their back and actually



Figure 7b

On bending forward, prominence is no longer noted. The rotation deformity remains corrected.

have better movement to the convex side than they had prior to operation.

Summary and Conclusions

1. Scoliosis is a complex deformity involving all bones, joints, nerves, spinal cord, intervertebral discs, muscles and ligaments of the trunk as well as the thoracic and abdominal organs.

2. Treatment is more effective when performed early and the deforming factors removed along with decrease in or elimination of the deformity. It is especially important to continue the normal bellows function of the chest in order to prevent emphysema and middle age heart failure in scoliosis.

340 Boulevard, N.E.

COLUMBUS' BRADLEY CENTER AWARDED GRANT

Dr. Leonard T. Maholick, Medical Director of the Bradley Center, Inc., Columbus, Georgia, has announced that the Center has been awarded a Mental Health Project Grant by the National Institute of Mental Health. This message was recently received from Mr. Edward J. Flynn, Chief, Mental Health Project Grants Section, Research Utilization Branch of the National Institute and stated that the National Advisory Mental Health Council in its recent meeting approved the Bradley Center applications for a project entitled, "Mental Health Training for Physicians and Ministers," in the amount of \$90,000.00 for three years. This award will permit the Center to develop and extend further some of its pioneering work which has already been underway for the past five years. The cur-

rent aim of the project is to demonstrate that, in communities (outside of Columbus) having little or no psychiatric facilities, physicians and ministers, the professions most significant in society's defense against mental illnesses and to whom most troubled people turn, will participate in specially developed training programs providing them with systematic, economic techniques of case management, and that using these methods in their daily work will effect beneficial changes in the pattern of providing care for individuals with personal problems. The project also hopes to demonstrate that such a training program can be executed economically by a mobile, flexible mental health team. Included in the plans are attempts to evaluate the project.

SCIENTISTS, MECHANICS AND HEALERS

Reid Gullatt, M.D., *St. Petersburg, Florida*

■ *The art of the practice of medicine remains
as important as ever.*

ALTHOUGH THE WORD *doctor* means *teacher*, for centuries the traditional role of the physician was predominantly that of healer. Consequently, until very recently, the primary object of the physician has been the care of the patient. After his basic education, both his training and his hospital experience have been built around this goal. In the past, as this goal of improved patient care was being pursued in the general hospital, special laboratories were working hard on research, and undergraduate and graduate medical education was being pursued in the university hospitals. Now, however, there is no clear-cut distinction between patient care, research, and education. This evolution will almost certainly continue to spill over into the functions of the general hospital, and there will continue to be more emphasis on patient care in medical education and training programs of the future.

Differing Functions

In this evolutionary period, when the functions of medicine have become less compartmentalized, the physician himself has had difficulty in keeping his personal functions from becoming more compartmentalized. Not many would object to dividing the physician's functions into that of the scientist, the mechanic, and healer. Those who did object would probably find that their objections were in the realm of semantics rather than objections in substance. This brings to mind the story of the Methodist Steward in the little Georgia town. In his first stewards' meeting, the young man made a motion to buy a new crystal chandelier for the sanctuary. The old chair-

man of the board ruled that the motion would not be discussed and not voted on for three reasons. In the first place, nobody there could spell it. In the second place, nobody in the whole congregation could play it. And, in the third place, what they really needed in the sanctuary was some more light. I think few of us will deny that there needs to be more light shed on the much discussed image of the physician today. It is possible that one of the reasons that the image of the physician today seems less illustrious than it was in years gone by is that these various roles of scientist, mechanic and healer cannot be handled perfectly by each individual who becomes a physician. Some of us simply do not have the versatility which it requires to balance appropriately all of these functions. One of the real difficulties in discussing the problem is that in those cases where each leg of the three legged stool is not balanced, some imbalance is acceptable and some is not.

By definition, the scientist is one who is devoted to scientific study or investigation, and science is any department of knowledge in which the results of investigation have been systematized in the form of hypothesis and general laws subject to verification. A mechanic is one who is engaged in mechanical employment, but the word mechanical means to operate as if by a machine or machinery. A healer is one who heals. To heal is to restore to health, to bring about remedy, to free from grief or worry. It is very obvious that only the healer is really concerned with people primarily. This then is the real problem. There need not be a higher level of purpose or intent in those physicians who work to heal people, but the healer must find satisfaction in working with people. This must be a satisfying experience to him because it is his primary goal. This is not really being taught

Presented at the 108th Annual Session of the Medical Association of Georgia, May 8, 1962, Savannah, Georgia.

in medical school, and somehow it must be.

Let us go back to the imbalance in the three legged stool. If the physician has a personality which leads his patient to believe that the physician can heal him, the physician will certainly be a success in terms of the volume of his practice. This can result in his becoming an almost pure mechanic just because of the volume of his endeavors and the inevitable machine-like handling of them. This is one of the commonest problems in the practice of medicine today. It is ironic that many of the potentially best healers wind up being some of the busiest and worst mechanics.

The Touch of the Healer

On the other hand, the physician who does not have the touch of the healer can do great harm regardless of his scientific or mechanical ability. Take the case of the man who was referred to an internist by his family physician. The internist, after a thorough work-up, made an astute diagnosis of disseminated lupus erythematosus. On making his diagnosis, the internist was obviously through with the patient, told him point blank what his chances and life expectancy were and wrote, I am sure, in his medical history Q. E. D. This patient wound up in the psychiatrist's office and, in expressing his experience with the young internist, made this remark to the psychiatrist, "He took all hope away from me!"

Inspiring Confidence

It would seem that this type thing is not necessary. It is so very obvious that each of us must attempt to develop the personality which is necessary to inspire confidence in our words and actions. It is also obvious that each of us may not be able to round out a personality which incorporates equal assets in the scientific, mechanical and healing realms. But it should be incumbent on each of us to try to develop basic qualities which will transmit to our patients the knowledge that we are trying to restore them to health or free them from grief or worry. This should make us big enough to take the time to handle even little problems in our patients when they are big to the patient.

Almost any imbalance in our trinity which leaves the physician short on the qualities of the healer renders the physician unsatisfactory to the patient. If this is an incorrectable personality problem, the physician can almost always be of value in research, teaching or institutional work where direct patient contact is not necessary. Anything short of a basic personality problem, however, could probably have

been corrected somewhere in the education or training of the physician had sufficient effort been made on the part of his teachers.

Imbalance on the short side of scientific knowledge is always tragic to both the patient and the medical profession. Although we must assume that when the physician has received his M.D. he is competent, we also realize that in the succeeding years he must continue a course of postgraduate medical education if he is to remain competent. Professional competency is considered almost entirely to be in the scientific realm. The overall concept of healing is considered the Art of Medicine. Mere experience alone is no guarantee that one shall achieve either. I believe that more attention should be given, and more competence required, in the Art of Medicine in our formal education and training. This, I feel, is not only possible but appropriate. Surely, there are many good physicians who are predominantly healers who could be added to our faculties along with our creative medical scientists and our true medical pedagogues.

The Mechanical Side

A lack of mechanical ability or an excessive reliance on a mechanical approach is a more difficult problem to discuss. The mechanical side of medicine may be that intensely specialized and flawless technique which is so important to good surgery. It may be the actual handling of too numerous patients in a necessarily busy general practice. It may be the way one makes routine the little problems which come up frequently. It may be the administering of shots of B₁₂ as a means of speeding patients through a busy schedule. The mechanics or technique of running a practice will certainly make or break the physician who deals with people. The most well-meaning healer who is a competent scientist may become a meaningless mechanic if he allows himself to become swamped because of his obvious ability and sincerity. And of course there will always be the few who only care to be mechanics in the first place in order to see how much money they can make.

Specialists Before Doctors

Dr. Alton Ochsner has said that we have too many specialists who become specialists before they become doctors. I do not mean to attempt to paraphrase this illustrious gentleman, but I feel strongly that I am saying the same thing that he has said when I say that we have too many physicians who have not first become healers who are practicing medicine on people. I feel that heredity and the medical school curriculum will take care of the scientists, both creative and practicing. I feel that in a

good training program the mechanical side of a physician's personality will be nurtured adequately. Even in Georgia, the patient is beginning to realize that a physician should not do neurosurgery without at least a year's internship.

Good Perspective

To summarize, our image is in good perspective in the scientific and mechanical realms. In the role of the healer, more of us are falling down than are making the grade if we are to believe the image. Now the image is certainly worse than reality, because we are rightly placed on a pedestal by even those who condemn us. But there are still enough practicing physicians who are not dedicated to healing who are distorting the image. We are suffering immeasurably as a group because of this lack of dedication. The cultists thrive, apparently because of this failure on our part. The cultist knows that the patient wants someone in whom he can have confidence and to whom he can feel close. They all exploit this desire or need of the patient. The true healer would never exploit his patient in any manner because of this relationship, but rather would want his patient to feel this way only because of the healer's ability, truthfulness, and sincerity of purpose. This, then, brings out a quality which I believe lies inherent in the personality of all true healers. I believe that the quality of transparent truthfulness is most fundamental. I believe that the healer is always himself and is always true to himself and to his profession and to his patient. I believe that the healer must, in fact, be either a Dr. Kildare or a Dr. Ben Casey as his own personality dictates; but he must

certainly be true to, and sincere in, this personality as he treats his patient. The Ben Casey phenomenon puts to rest for all time the legend that most people want a dear old gentleman in a black coat who will comfort always, relieve often, and cure sometimes. It should be obvious to all of us that the patient public wants a competent, sincere and dedicated physician whose goal is to restore them to health.

I have found the hard way in the general practice of medicine that there are many patients whom one simply cannot afford to comfort. I have found many with whom, in order to heal, one must be appropriately harsh. This is something else that students could be prepared for in medical school.

Leaving to Chance

The thought which I leave with you today is that we as physicians are probably doing what we should in medicine in the scientific and in the technical realms. We are leaving to chance the success or failure of today's physician in the Art of Medicine. This is our major shortcoming, and it may prove the downfall of medicine as we know it today. I feel each of us should rededicate our professional lives so as to help overcome this shortcoming. Let each of us encourage our colleagues to do the same. Let each of us encourage our Alma Maters to start teaching actively the Art of Medicine in a new and more meaningful manner. This new manner may be in a Department of Medical Philosophy, a Department of Medicine and Religion, a Department of Family Medicine, or in an autonomous Teaching Clinic. But however each of us may help, let each do his job well.

6395 29th Avenue, North

PHYSICIAN APPOINTED TO STATE BOARD OF REGENTS

On January 1, 1962, Dr. John A. Bell, Jr. of Dublin began serving a term of office as a member of the prestigious 15 man State Board of Regents. Announced on December 4th by out-going Governor Ernest Vandiver, Dr. Bell's appointment will be from January 1 to January 1, 1963 to 1970 inclusive.

Dr. Bell was graduated from the Medical College of Georgia in 1934. Excluding six years military service during World War II, he has done General Practice in Dublin since 1935.

He is a member of the Laurens County Medical Society, the Sixth District Medical Association, MAG, Southern Medical Association, AMA, World Medical Association and the Georgia Chapter of the American Academy of General Practice.

Dr. Bell has long been active in the affairs of the Medical Association of Georgia. During the years 1960-61 he served as Chairman of the Legislative Committee. He is currently a Vice Councilor from the Sixth District and Chairman of the Sub-Committee for State Legislation.

The Board of Regents is the State agency charged with primary responsibility in administering the affairs of the University System of Georgia. In addition to the obvious institutions such as the University of Georgia, Georgia Tech and others, the System includes the Medical College of Georgia. It is with this institution that Dr. Bell, as the only physician on the Board of Regents, will bring a specialized talent unique to the Board.

A PLAN FOR CONCERTED ATTACK ON THE STAPHYLOCOCCUS

Jack C. Norris, M.D., *Atlanta*

■ *The efficacy of combined vaccine and antibiotic therapy is discussed.*

STAPHYLOCOCCIA INFECTIONS have been notable since the germ was first isolated by Ogston in 1881. *Albus*, *aureus*, and *citreus*, derive their names largely from the pigments they produce. In addition to these, there are other minor strains which also cause infections, usually milder in character. Generally, the more dangerous are coagulase positive, coagulate milk, liquefy gelatin, ferment lactose, glucose and sacchrose. Staph are resistant, but killed easily by boiling water in three to five minutes. Staph are dependably dangerous, producing toxins, food poisoning, cellular and tissue necrosis. They may be primary invaders, or secondary, and can cause severe complications following surgery.

Area Infections

The problems of therapeutic importance here shall deal primarily with such conditions as boils, small abscesses, carbuncles, infected skin, middle ear or canals, sinuses, and the bronchi and lungs. These areas are the ones in which we encounter infections more often than others.

Staphylococci may be transmitted from one person or patient to others. Human or animal carriers may take part in this. It is more active in warmer climates than cold. If resistance is low, and the infection be marked, septicemia or pneumonia may result. It is amazing, however, to observe people with acne, or other skin lesions, who seem to go a considerable amount of time before developing more extensive lesions. Something alters the tissue resistance and a virulent reaction follows.

Poison Producer

It has been known for many years that the *Staphylococcus* produces many virulent hemolytic poisons. It will also stimulate antibodies in the blood and tissues; however, the antibody response does not appear or rise up quickly as one would hope; but comes, nevertheless, and this well-established fact is largely the basis for this paper. With antibiotics, plus ordinary principles of therapy, including vaccines, we are now able to combat the Staph infections with considerable success.

First, I should like to emphasize the autogenous vaccine in adjunctive treatment. The offending Staph is qualified by its appearance on blood agar. Here we may also determine the hemolytic quality. We then check it for coagulase activity, and perhaps the reactions in milk and gelatin. In culturing abscesses and boils, the skin must be cleaned very carefully by using 70 per cent alcohol as local applicant. When the alcohol has dried, the lesion is cautiously incised, and small quantities of the pus, or the sanguinous secretion, removed. In my lab we use two methods for culture: One, 12 c.c. *heart-brain broth*, and another *blood agar*. Agar with rabbit blood is very good.

Following 24-48 hours of growth, the brain-broth tube is centrifuged and the supernatant part removed. The concentrate is reabsorbed by an isotonic sterile saline, 10-15 c.c., and if the culture is of a pure strain, we then add several loopsful of the blood agar growth to this mix. The saline suspension is thoroughly shaken up, and then placed in a 15 c.c. vial with rubber overlying cap, non-leaking type; 0.2

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c.c. sat-phenol is added, and the vial placed in *boiling water bath* for not less than six minutes. The last step positively sterilizes the vaccine; I have never seen this method fail.

Test Before Vaccine

After the vaccine is prepared, if I am to treat the patient, I do a skin test, administering *one* minim into the skin with a tuberculin syringe and note the reactions, 15 minutes and after 18-24 hours. The reactions are quite variable, clearly discernible, almost never marked, but occasionally may be shocking! *This is important*, because if so, caution is necessary now to make a more diluted dose. I do not personally recall ever having a patient who had a serious allergic reaction from the Staph vaccine, but others have. The majority of patients may be safely given a dosage starting with one minim of the suspension as suggested, increasing each dose an added minim, administered about three times a week. As the dose reaches eight to ten minims then the days may be separated, and the vaccine injected once a week. After a period of 20 days, the patient usually begins to note an excellent improvement.

Acute Infection

If the infection is acute and particularly disturbing, such as boils on the face, or around the nasal region, and the physician feels that antibody response needs to be quickly stimulated, we suggest that the vaccine be given every other day (*one minim*) into the skin, making a slight swelling at site of injection, which soon disappears. Occasionally Schwartzman's phenomenon may occur, and the vaccine must be temporarily laid aside.

Bacteriophage can also be used in treating Staph infections, but my experience with the substance is scant.

Vaccines have helped many, and have produced satisfactory results in at least 80 per cent of the cases. In 1960, I prepared a series for Dr. Merrill Lineback, who used them for treating staphylococci infections of the head, neck and arms. In 88 patients, 53 cures resulted. McCoy and Kennedy¹ reported 60 staph infections also treated with vaccines. Five failures occurred.

For many years an argument has continued among doctors, some of whom think vaccines to be worthless, others believing them to be helpful. Many factors are important, however, and are often neglected. One is that the patients will take a few "shots" and then quit. Patients also dislike running up a large office visit charge. However, if the treatment is maintained long enough, until visible results are noted, the patients are usually satisfied. *Carbuncles* are a particularly difficult problem and are time consuming. It is most important also to em-

phasize a few other steps, such as the necessity of impressing the patient about personal cleanliness, to try not to spread the infection, or pass it to others; to make them understand the importance of food. We usually advise against eating fatty-foods or two many sweets, eliminating egg protein, hot spicy foods, chocolate, or any substances to which the patient seems allergic. It is hardly necessary to emphasize blood glucose, or to disclose diabetes, if it should exist. Diabetes and Staph infections appear to aggravate one another.

With those few thoughts before us, let us now proceed to the second phase of the plan, which shall be the *coordinated use of antibiotics in conjunction with vaccines*.

Valuabe Combination

While the antibiotics are all-powerful and almost magic, in most instances they seem only to depress Staph infections rather than to cure them, and here is why we have a valuable combination in the use of the vaccine.

I have been performing antibiotic sensitivity tests against the Staphylococci, using a modified method reported previously.² It is a simple technique, gives a rule to go by, and has a decided advantage over the dilution testing methods in that we get a clearer, neater picture of just what is "cooking," when performing the test on blood agar. A heavy centrifuged suspension of the germs is prepared, either in saline or in bouillon, and a drop of the culture is placed in divided spots on the agar plates, and a sensitivity disc dropped on top. As a rule, the disc absorbs the bacteria, but leaves plenty of germs around the disc edges. In 18-24 hours of culture the sensitivity reading is observed by the surrounding zones of activity, which are clearly seen, and measured into terms; one

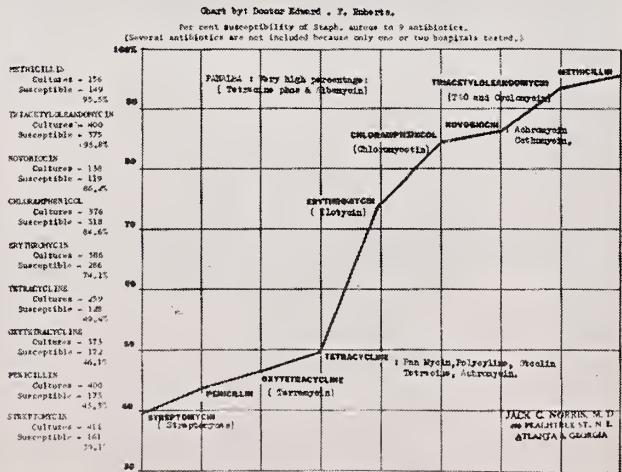


Chart showing antibiotic sensitivity, report by E. F. Roberts, M.D., and Jack C. Norris, M.D. The findings are very similar, with the exception that Chloromycetin and Pan Alba, as used by Dr. Norris, excel Novobiocin and Tao in activity of the sensitivity plate tests. All listed here are dependable, however.

NORRIS / Continued

plus, two plus, three or four, each plus indicating the reaction—zero as none. This technique seems to be well understood by the doctors who use my lab, and as a rule the antibiotic activity is reflected in the patient's good response from the treatment.

Evaluation of Strains

Over and over, we have isolated Staphylococci from many different lesions, and several strains have been evaluated. Our checks show that Hemolytic types react as follows: *Chloromycetin*, *Pan Alba*, *Albamycin*, *Kantrex*, *Furadantin*, *Resistopen*, and *Prostaphlin* lead the list as killers par excellence in that order, being about equal in effect. Erythrocine, Tao, Declomycin, Altafur, follow along. Terramycin and Vancomycin are also good. Madribon helps. We note quite a good antibiotic activity against Staph Aureus by Humatin, but have not tested it enough to know much about it. I must confess, however, in all fairness, that one should not be too dogmatic in his statements about any of the antibiotics, because on certain occasions we have noted unusual and often unexplained effects with many, both in testing sensitivity, and in the treatment. Penicillin in some patients will also suppress Staph infections, but will seldom cure them; but strange as it may seem, Maxipen sometimes amazes me. I do not know too much about the other cillins, but great possibilities are noted, according to reports now coming out.

Isolation of Organism

We now approach the round-up stage of this paper; that is to present the final plan of action in any given Staph infection, which is, *first to isolate the organism*, classify it, and if convinced that it is the guilty culprit, make an autogenous vaccine, and if desirable: *add several other strains* of organisms from other cultures. This has an added value.

Then perform the antibiotic sensitivity plate test

as I have described, noting which one destroys the germs most actively, and administer the proper dosage, using, if desirable, two or more sensitive antibiotics in combination, being sure that the patient is not allergic to any one.

Such a suggested method of treatment is of course fairly well shown, and is used frequently. However, I want to make this added report because almost weekly patients are seen who have gone days and weeks spending large amounts of money for hit or miss antibiotics and other unnecessary medication for Staph infections, none of which has helped, or at least given unsatisfactory results; then suddenly the doctor rouses to the question, "Why not a vaccine?" Often he is embarrassed by the patient, who makes the request. That should not happen.

Treatment

When a patient develops staph septicemia, he can be treated with Vancomycin. Geraci and Welman cured 25 of 34 patients. One gram intravenously every 12 hours gave adequate serum levels. (*Arch. of Internal Medicine*: May 1962.) There may also be an antibody increase if Staph vaccine is given intradermally as an adjunct.

In closing, may I add that reports made by others, some of whom I have named, dealing with Staph, and knowledge gleaned from my own observations, encourages me to feel that there can be very little doubt about the efficacy of what is recommended here, and that the therapy represents a sound, economical, conservative plan of attack; and my thoughts are humbly passed on for trial, especially for those patients who have proven to be resistant to other forms of medication.

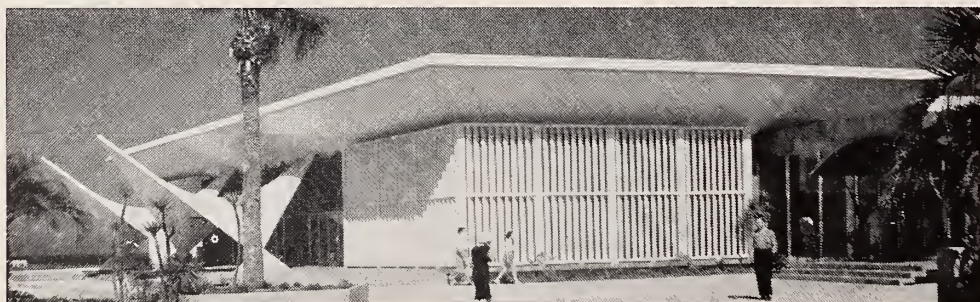
490 Peachtree Street, N.E.

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2. Norris, Jack C.: Testing Sensitivity to Antibiotics, *Medical Times*, Pages 961-962, August, 1958.

HAVE YOU MADE YOUR ANNUAL SESSION RESERVATIONS?

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AQUARAMA, JEKYLL ISLAND, GEORGIA

MAY 5-8, 1963

1963 CALENDAR OF MEETINGS

State

October 23, 1962-March 14, 1963—Series of Postgraduate Courses presented by the Medical College of Georgia's Department of Continuing Education: March 12-14—"Gynecologic Problems in Private Practice."

March 11-13—Second Annual Postgraduate Course, "Cardiology for the Pediatrician," sponsored by the Department of Pediatrics, Emory University School of Medicine, Grady Memorial Hospital Auditorium, Atlanta.

March 28-30—Annual Meeting of the Georgia Society of Ophthalmology and Otolaryngology, General Oglethorpe Hotel, Wilmington Island, Savannah.

April 25—Eighth Annual Albany-Southwest Georgia Medical Seminar, Grand Ballroom, Albany Hotel, Albany.

May 5-8 — 109th Annual Session of the Medical Association of Georgia, Aquarama, Jekyll Island, Georgia.

Regional

October 1962-November 1963—Fourteen Postgraduate Courses offered by the University of Tennessee College of Medicine: March 7-8—"Urinary Tract Diseases-Diagnosis and Treatment;" March 18-22—"Elementary Clinical Electrocardiography;" March 21-23—"Surgery of the Hand;" May 15-17—"Emotional Disturbances of the Adolescent;" May 22-24—"Fractures and Dislocations."

March 6-9—American Orthopsychiatric Association, Inc., Shoreham Hotel, Washington, D. C.

March 18-21—Southeastern Surgical Congress, Americana Hotel, Miami Beach, Fla.

March 22-27—North American Clinical Dermatologic Society, Diplomat, Hollywood, Fla.

March 24-28—International Anesthesia Research Society, The Americana, Bal Harbour, Miami Beach, Fla.

March 29-31—American Otorhinologic Society for Plastic Surgery, Fountainebleau Motor Hotel, New Orleans, La.

April 1-5—Thirty-sixth Annual Spring Congress in Ophthalmology and Otolaryngology sponsored by the Gill Memorial Eye, Ear, Nose and Throat Hospital, Roanoke, Va.

April 16-19 — American Dermatological Association, The Homestead, Hot Springs, Va.

April 17-20—Sixteenth Annual Meeting of the West Virginia Academy of Ophthalmology and Otolaryngology, Greenbrier Hotel, White Sulphur Springs, West Va.

April 21-22 — American Laryngological Association, Hollywood Beach Hotel, Hollywood, Fla.

April 23-25 — American Laryngological, Rhinological and Otolological Society, Hollywood Beach Hotel, Hollywood, Fla.

April 25—American Society for Head and Neck Surgery, Hollywood Beach Hotel, Hollywood Beach, Fla.

May 13-15—American Gynecological Society, Roosevelt Hotel, New Orleans, La.

May 27-29—American Ophthalmological Society, The Homestead, Hot Springs, Va.

National

February 28-March 3—College of American Pathologists, Rice Hotel, Houston, Tex.

February 28-March 4—American College of Cardiology, Ambassador Hotel, Los Angeles, Calif.

March 16-21—Fifteenth Annual Teaching Seminar of the International Academy of Proctology, Las Vegas, Nev.

March 17-22—American College of Allergists, The Americana, New York City.

March 18-30—Department of Otolaryngology, University of Illinois College of Medicine, Postgraduate Course in Laryngology and Bronchoesophagology, Chicago, Ill.

March 24-29—American College of Allergists Graduate Instructional Course and Nineteenth Annual Congress, Americana Hotel, New York City.

March 29-31—American Society of Internal Medicine, Brown Palace Hotel, Denver, Colo.

March 29-April 5—American Academy of General Practice, Chicago, Ill.

April 1-5—American College of Physicians, Denver Hilton Hotel, Denver, Colo.

April 8-10—American Association for Thoracic Surgery, Shamrock Hilton Hotel, Houston, Tex.

April 21-24—American College of Obstetricians and Gynecologists, Statler Hilton Hotel, New York City.

May 27-31—Five Day Refresher Course in Pediatrics for Pediatricians and General Practitioners, The Children's Hospital of Philadelphia, Philadelphia, Pa.

June 16-20 — American Medical Association Annual Meeting, Atlantic City, N. J.

**Whatever happened
to handkerchiefs?**

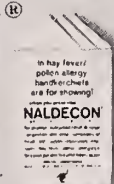


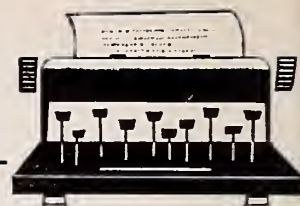
Remember when handkerchiefs were used for stuffy or runny noses? *That was before Naldecon.* Naldecon lets your head-cold patient breathe the way he should. Through the nose. Honest relief that lasts up to 8 hours with one sustained-action tablet. (When you need it, even *half* a tablet retains the sustained-action feature.) The counterbalance between *two* antihistamines and *two* decongestants* usually gives excellent results—seldom causes overstimulation or sedation. Keep handkerchiefs for showing. Prescribe Naldecon.

*Each tablet contains phenylephrine HCl 10 mg., phenylpropanolamine HCl 40 mg., phenyltoloxamine citrate 15 mg., chlorpheniramine maleate 5 mg.—half in the outer layer, half in the sustained-action core. Each teaspoonful (5 cc.) of Naldecon Syrup contains the equivalent of one-half tablet.

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Mrs. W. Bruce Schaefer

Mrs. W. Bruce Schaefer Appointed State Welfare Director

RECOGNITION OF ABILITY and achievement was paramount in the recent appointment of Mrs. W. Bruce Schaefer of Toccoa to the Directorship of the State Department of Public Welfare. Governor Sanders accorded this high honor to Mrs. Schaefer early in January, expressing his full confidence in her capabilities to assume this responsible position in our state government.

Mrs. Schaefer's activities in behalf of the medical profession are known throughout the state. She is a former President of the Woman's Auxiliary to the Stephens County Medical Society, Stephens County Unit of the American Cancer Society, Woman's Auxiliary to the Ninth District Medical Society, Woman's Auxiliary to the Medical Association of Georgia, the Better Health Council of Georgia, the Georgia Society for Crippled Children and Adults, and the state chairman of Doctor's Day program.

Her interests have ranged from leadership activities in her Church, Parents and Teachers Association, United Daughters of the Confederacy, Georgia Federation of Woman's Clubs, Ninth District and Georgia State Democratic Executive Committee, Civil Defense, White House Conference on Children and Youth, Governor's Conference on Recreation and Leisure Time Use, Georgia Citizenship Institute, and the State Board of Education.

A list of Mrs. Schaefer's accomplishments read like "Who's Who of American Women," which incidentally took note of her activities in 1959. Mrs. Schaefer has been active as Democratic National Committeewoman, Executive Committee Member of the Democratic National Committee, Resolutions Committee of the Democratic National Committee,

Member of the Ninth and Georgia State Democratic Committee, Legislative Chairman of the Georgia Federation of Woman's Clubs, Vice Chairman of the Georgia Adult Education Council, Vice President of the Georgia Association for Mental Health, Vice Chairman of the Georgia State Board of Education—and has now been appointed Director of the State Department of Public Welfare.

As the wife of a Toccoa surgeon, Dr. W. Bruce Schaefer, Mrs. Schaefer has two children and is a graduate of Brenau College. She has taught speech at Gordon Military College and the University of Georgia System. The Schaefer family has a tradition of public service. All physicians are familiar with Dr. Schaefer's having been President of the Medical Association of Georgia, chairman of many MAG Committees and a member of the MAG Council from the Ninth District, and having headed the Schaefer Committee on Mental Health at the request of the Governor in the assessment of facilities at Milledgeville.

Suffice it to say that the physicians of Georgia have full confidence in the new Director of the State Department of Public Welfare, as Mrs. Schaefer's record of accomplishment is well known to the profession. We believe her leadership in this capacity will benefit the people of Georgia, and to this end the profession pledges its cooperation to Mrs. Schaefer and the Department she directs. We add our hearty commendation to Mrs. W. Bruce Schaefer and accord her honor for this achievement knowing full well she will meet the challenge of this responsible, high office.

The Technique of Radioisotope Photoscanning

THE TECHNIQUE OF RADIOISOTOPE PHOTOSCANNING has been little used in Georgia or the Southeast until recent months. The principal reasons for this have been unsatisfactory experience with previous radioisotope scanning techniques, and the relatively high cost of modern photoscanning equipment. Older techniques for thyroid and liver scanning produced only dot scans of a statistically unreliable nature, and without a photographic display of the scanning image.

Improved Equipment

Due to improved equipment and new isotopes, it is possible now to reliably scan the brain, thyroid, heart (differentiation of pericardial effusion from cardiac enlargement), liver, spleen, kidneys, and recently the pancreas by the use of seleniomethionine (not available commercially).

Equipment improvement has come about through the use of improved collimation, pulse height analysis, and the simultaneous production of a photographic image on an X-ray film. Following body uptake of the radioactive isotope used for the specific organ to be scanned, a lead collimator and sodium iodide crystal (probe) are moved by electrical motors in a rectilinear fashion over the organ to be scanned. The gamma emissions from the organ are collimated, and cause scintillation of the sodium iodide crystal. Pulse height analysis rejects unwanted background, and the intensity of the gamma emissions energizes a cathode-ray tube connected to a

light source which makes dots of proportionate degrees of blackness and grayness on a photographic film. Simultaneous dot scans are made on metallic coated paper.

Technique

By this technique, size, shape and position of the thyroid gland can be shown as well as "hot" or "cold" thyroid nodules. Brain tumors can be demonstrated with a high degree of accuracy, as can brain metastases. In the liver, metastases and other space occupying lesions can be shown, and the size, shape and position of the spleen can be demonstrated. Superimposition of scans on a plain film of the abdomen demonstrates relationships to other organs.

The size, shape, position and vascularity of the kidneys may be shown by the ability of renal tubular cells to pick up Mercury ²⁰³ Neohydrin.

Cost

The equipment costs about \$10,000. A technician can be trained to do the scans in about two weeks. This is a practical diagnostic adjunct in a medium sized private hospital. Using a Picker Magnascanner at The Piedmont Hospital in Atlanta, Georgia, we have done 230 scans in seven months. This procedure has been helpful in many areas, but particularly in unilateral kidney disease and renal neoplasms.

*Ernest G. Smith, Jr., M.D.
Radiologist, Piedmont Hospital
Atlanta, Georgia*

The Monk Study

IN 1944 a group of men came to Conyers, Georgia, and began the establishment of a Trappist Monastery. These men are Roman Catholic Monks who follow the rule of St. Benedict which was written sometime during the sixth century A.D. The main

points of this rule are embodied in the motto "Ora Et Labora," worship and work. As part of this rule the monks divide their activity into prayer, study and heavy manual labor. These men eat a diet that is strictly lacto-vegetarian and also refrain from talk-

ing, smoking and alcohol. They take the vows of poverty, chastity, obedience and stability, the latter meaning that they will remain in this same monastery for the remainder of their lives.

Interest Aroused

This unusual form of life aroused a great deal of interest in Georgia. In 1955, when the relationship of diet to atherosclerosis first became of interest, the idea occurred to members of the Cardiovascular Disease Control Service of the Georgia Department of Public Health that this group would be of interest to study. From this small group in Georgia there began a dietary study that has since grown to include nearly 2000 monks throughout the United States and Canada. Another group of Roman Catholic Monks, the Benedictines, were chosen as a control group because they lead a very similar life except that they consume a typical American diet including meat and much more fat.

Difference in Groups

The objective of the study is to determine, over a long period of time, whether there is a difference between these two groups in the incidence of atherosclerosis and its complications. The annual measurements made on the volunteers in this study include a complete medical examination, electrocardiogram, X-ray and serum studies of cholesterol, phospholipid, total lipid and lipoprotein electrophoresis. The individual diets of each subject are studied closely. The total number of calories consumed and the relative amounts of fat, protein and carbohydrate are calculated, as well as the specific types of fat and fatty acids. The data are analyzed on high speed computers in the State Health Department. Any deaths that occur in the groups are evaluated with an autopsy using standardized methods of examina-

tion of the heart and aorta to determine the degree of atherosclerosis.

It has been found that the Trappists on the average have a much lower fat intake than the Benedictines. The Trappist group has a significantly lower level of most serum lipid constituents, the serum cholesterol concentration differing by approximately 20 milligrams per cent less than the Benedictines. The incidence of myocardial infarctions, angina pectoris, and abnormal electrocardiograms is also significantly lower in the Trappist group. As yet the number of monks showing unequivocal evidence of atherosclerosis is small but it is presumed that as the study continues over the years and as each monk is studied for his lifetime, more clear cut evidence of atherosclerosis will be gathered. In essence this study demonstrates so far that these two groups of men are nearly ideally matched except for dietary intake and present an unusual opportunity for a controlled study of the influence of diet upon atherosclerosis. Of necessity these men must be followed for many years before any presumptive relationships between diet and atherosclerosis can be made.

Support

The main support for this long range investigation has come from Federal Government research funds, but the role of the State Health Department is all important. It is the type of study that can only be done by a stable organization with sustained interest in community health, facilities for lifetime "longitudinal" record keeping and continuing efforts in spite of changes in personnel. This type of research activity by a State Health Department is further evidence of Georgia's pioneering work in the control of disease.

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TWENTY-SIXTH ANNUAL MEETING SLATED BY NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

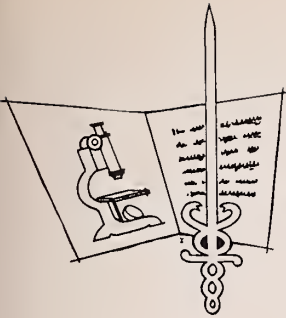
The twenty-sixth annual meeting of The New Orleans Graduate Medical Assembly will be held March 4, 5, 6 and 7, 1963, with headquarters at The Roosevelt Hotel, New Orleans, Louisiana.

Nineteen outstanding guest speakers will participate, and their presentations will be of interest to both specialists and general practitioners. The program will include fifty-five informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposia, medical motion pictures,

round-table luncheons and technical exhibits.

Following the meeting in New Orleans, arrangements have been made for a clinical tour to Mexico leaving New Orleans via air on March 8. The itinerary includes visits to Mexico City, Cuernavaca, Taxco and Acapulco, returning on March 23. Optional extensions in Mexico may be arranged.

Details of the New Orleans meeting and the tour are available at the office of the Assembly, Room 105, 1430 Tulane Avenue, New Orleans 12, Louisiana.



GASTRIC CARCINOMA

Hoke Wammock, M.D., *LaGrange*

CANCER OF THE STOMACH still poses as one of the major problems in cancer control. The only bright feature or hope for cancer of the stomach is from the epidemiological viewpoint, that there is continued decline in the morbidity and mortality among whites. The drop in morbidity and mortality of stomach cancer is also accompanied by a corresponding decrease for the total digestive system and peritoneum. This decline is evident in each sex and age group.

According to recent studies, no other country, with adequate death registration, has a lower rate.¹

The mortality for cancer of the stomach is higher in the Negro than in the white. There is evidence that white men and women in the lower social class also have a higher cancer incidence than those in the higher social class.

Despite this decline in incidence of cancer of the stomach, the early detection is rather perplexing, and correspondingly, the average survival rate is still less than ten per cent. The old adage of early suspicion, recognition, and adequate therapy should improve our results, but apparently there is still something lacking, for far too many people die of this disease. The best figures have been obtained when the disease is detected early and a sub-total gastric resection is performed, as contrasted to extended radical surgery, when the disease has spread to adjacent lymphnodes.

Inasmuch as football season has just passed, we might apply one of the principles in a football contest to the patient with gastric complaints, or a gastric ulcer. The principle is "pursuit football." The team that usually wins is the team that plays "pursuit football." "Pursuit of the symptomatology" is essential for detection and eradication of the disease. We must maintain a high index of suspicion, and definitive studies must be made to rule out the possibility of malignancy.

What are some of the findings that may suggest malignancy? Achlorhydria and pernicious anemia may be associated with malignancy. Also the location of the ulcer (greater curvature, pre-pyloric region) and delayed healing of gastric ulcer on a controlled dietary regime may suggest malignancy. The therapy for supposed gastric ulcer should not exceed five weeks, after which any roentgenographic evidence of persistence of the ulcer is an indication for operation.

Does a gastric ulcer possess a malignant potential? If so, should it not be removed when the diagnosis is first made, and can be demonstrated roentgenologically. There are those who regard gastric ulcer as potentially malignant, thus every patient with a gastric ulcer should be subjected to operation. This responsibility rests upon us, if we are to control gastric cancer. This does not infer that all patients with gastric ulcer will be operated upon needlessly, but we must give most careful consideration to the problem at hand, maintaining control of the patient, pursuing every facet in order to insure the safety and the well-being of the patient.

There are, of course, many other inherent factors that enter into the picture for the curability of cancer of the stomach: histological type, the rate of growth, metastatic potential, the extent of the disease at the time of surgical exploration, and the extent of the surgery performed.

With present day facilities and knowledge, we should be able to increase the survival rate, but unfortunately, the disease gains considerable headway before it is detected and surgically removed.

West Georgia Cancer Clinic

REFERENCE

1. Haenszel, William: *contra cancrum*, *Acta Unio Internat.*, 17:347-364, 1961.

Approved by the Professional Education Committee, Georgia Division, ACS.



ENDOCARDIAL SCLEROSIS

Martin H. Smith, M.D., *Gainesville*

PATHOLOGICAL DESCRIPTIONS of Endocardial Sclerosis under a varying nomenclature have been appearing in the literature for more than 150 years. It has only been chiefly in the past decade that it has been considered in the clinical diagnosis of infants manifesting heart disease. The experience of the past several years dictates that this diagnosis should be considered in the infant who suddenly shows evidence of heart failure and who has shown no previous evidence of heart disease. It must likewise be considered as possible secondary involvement of the infant with known congenital heart defects; an involvement which can influence the success of remedial surgery in these cases.

Pathological Picture

The pathological picture is one of an increase in fibrous tissue in and beneath the endocardium, with extension of fibrous strands into the myocardium. There is elastic tissue hyperplasia with similar extension. This picture may be found as the sole cardiac pathology (Primary Endocardial Sclerosis). It has been described in many of the types of congenital heart defects (Secondary Endocardial Sclerosis). In these latter instances the process seems to increase with age.

Etiology

The etiology of this process has never been proven. The original concept that it represents a fetal endocarditis has very little support now because of the lack of proof. The most widely held present theory is that it represents a developmental defect. This is supported to some extent by the recent reports of primary endocardial sclerosis in siblings and in twins. It is of particular interest that the site of endocardial thickening in the instances of secondary endocardial sclerosis seemed to fall into a

predictable pattern; this pattern being determined by the site of increased pressure, abnormal flow, or of jet effect.

Symptomatology

The symptomatology of this defect may first be manifested any time in the first few weeks or months of life. The most common first symptoms are those of congestive heart failure. Occasionally the only symptoms may be failure to eat, gain weight and thrive, or simply vomiting. Cyanosis is not seen except in pronounced failure. Murmurs have been heard in some of the children with primary endocardial sclerosis but most of them have no murmur.

X-ray of the chest will show an enlarged heart, usually globular shaped, and without any characteristic configuration. There may be evidence of congestion in the lung fields, but no increased or decreased flow. Fluoroscopic study will usually show that the enlargement involves all chambers.

The EKG usually shows evidence of left ventricular hypertrophy and occasionally there is flattening or inversion of the T waves.

Since there are no diagnostic characteristics of the clinical picture, X-ray, or EKG in this disease, the diagnosis in the living infant must be based on conformity within the previous description and on exclusion of all other possibilities. The differential diagnosis must include chiefly, coarctation of the aorta, and the more rare possibilities such as glycogen storage disease and anomalous origin of the coronary arteries.

Treatment

Treatment of Endocardial Sclerosis must be largely symptomatic treatment. Surgical treatment

has been attempted but has not gained wide acceptance. At the present time the most helpful treatment is in the form of vigorous combating of the congestive heart failure that is the usual result of the disease. This may involve digitalization, a low salt formula and diet, the use of diuretics, and the use of oxygen. The response to this regimen may, in some instances, be very rapid and gratifying. It is often felt that the rapidity of the response may

furnish some guide as to the immediate prognosis, i.e. that those who respond rapidly may do well for some time on continued digitalization and careful management. However, the ultimate prognosis in most all instances of Endocardial Sclerosis remains a poor one. Death can be expected in more than 90 per cent of these cases before two years of age.

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Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

GOVERNMENT INCREASES DRUG CONTROL

The federal government appreciably increased its controls over the clinical testing of new drugs, including antibiotics, with new regulations effective Feb. 7.

The new regulations of the Food and Drug Administration require that the FDA be put on notice and given full details about the distribution of drugs for investigational use; that clinical investigations be based on adequate studies on animals, and that the clinical tests be properly planned, executed by qualified investigators, and that the investigators and the FDA be kept fully informed of the adverse findings of other investigators during the progress of the investigations.

If an investigation develops evidence that the drug is not safe or is ineffective, the FDA said it will order discontinuance of clinical tests.

The old regulations did not require either an initial notice to FDA of a clinical trial of a new drug or subsequent reports on such use.

Before they were announced in their final form, numerous modifications were made in the version published on August 10, 1962, as proposed regulations. More than 300 written comments of the proposed regulations were received by the FDA. In addition, FDA officials met with representatives of the AMA and various other interested scientific groups.

The Pharmaceutical Manufacturers Association credited the Department of Health, Education and Welfare and the FDA with modifying the regulations as originally proposed sufficiently that "most of the major difficulties found by reputable medical scientists" had been resolved.

But the PMA said "the burden of paperwork imposed by the new regulations is enormous."

"The success of the department meeting its stated goals will of course depend in large part on the wisdom of administration of these regulations," the PMA said. "It is hoped that remaining troublesome problems may be resolved in the near future by appropriate amendments."

One modification was designed to permit some flexibility in the planning of the investigation of the safety and effectiveness of a new drug. Another modification cut down on the record-keeping requirements.

To meet criticisms that the regulations as originally proposed would impinge upon the physician-patient relationship by calling for inspection of the clinical rec-

ords, the FDA said:

"The provisions for inspection of the patient's records have been modified to make it clear that the investigator may withhold the names of volunteers or patients unless the records of a particular volunteer or patient require a more detailed study of drug effects, or unless there is reason to believe that the records do not represent actual results obtained.

"... if the record has been sent to the sponsor by the investigator, there is no confidentiality, and the record is to be made available by the sponsor for inspection by a properly authorized employee of the Department of Health, Education and Welfare. Where the record has not been sent to the sponsor, the investigator is required to maintain it and make it available upon request of a scientifically trained and specially authorized employee of the Department."

The proposed regulations dealing with publication of findings of investigators were construed by some as restricting free flow of scientific information. But the FDA said the regulations were "not intended to bar factual news reporting to scientists or the public."

The proposed regulations also were said to deny extremely important new drugs, not yet approved for general distribution, to patients who might need them urgently as a life-saving measure. The FDA denied this, saying "there is no bar in the regulations to giving the necessary instructions to and obtaining the necessary commitments from a new investigator by telephone in case this is needed to save a life."

Pending further consideration, radioactive new drugs were exempted from the new regulations if they are shaped in accordance with current regulations of the Atomic Energy Commission.

FDA Commissioner George P. Larrick said that the regulations as issued provide strong and necessary controls over the investigational use of new drugs and meet all of the new provisions in the Kefauver-Harris Amendments of 1962, including assurance that patient consent to the use of investigational drugs be obtained by the investigators, unless in their professional judgment this is not feasible or is contrary to the patient's best interest.

However, the new regulations were issued under an old law. The drug testing provisions of the new law do not become effective until next May 1.



"A SURGEON'S RESPONSIBILITY"

John L. Moore, Jr., *Atlanta*

AT THE END OF NOVEMBER, 1962, a decision of the Court of Appeals of Georgia became final. This decision is in the process of further appeal to the Supreme Court of Georgia, but contained important principles to mention at this time, although the Supreme Court may, of course, change them.

Case for Decision

A new infant required a total blood change-over operation. The child was brought to the hospital on the instructions of the surgeon and turned over to a nurse in charge of the ward. The surgeon directed that the infant be prepared for the operation. The hospital's employees placed the infant in an incubator and immobilized her with straps. The petition alleged that the hospital's employees placed the child's left foot in a position where it touched a 150 watt electric light bulb in the incubator which, in normal procedure, would have been removed before placing the infant in the incubator. The incubator had a cover with an opening in the center to allow the surgeon to perform the required operation at the umbilical site. The cover, however, concealed the 150 watt light bulb from observation by any one unless the cover was removed, according to the petition. The plaintiff's petition went on to allege that the surgeon came into the operating room and proceeded with the operation without removing the cover from the incubator or making any inspection which would have resulted in his seeing the position of the child's foot. The operation was a complete success, but the child's foot suffered severe burns, according to the petition. Approximately three-fourths of her foot had to be amputated eventually.

The baby's representatives sued the surgeon as

well as the hospital. The theory of the suit against the surgeon was that he was negligent in failing to remove the cover from the incubator when entering the operating room to determine whether the baby was properly placed in the incubator and whether the electric light bulb had been turned off and taken out of the incubator according to proper practice.

As will be immediately recognized, a decision by the Court holding a surgeon liable in this case would, by similar reasoning, make him liable for many other administrative duties of hospital employees. For example, the sterility of the operating instruments and of sponges might well be held to fall within the same reasoning making the surgeon responsible for checking such sterility before proceeding to operate.

Decision for Surgeon

The Court of Appeals of Georgia decided in favor of the surgeon. The Court pointed out that a physician can spend only a short time at the bedside of each patient and he must therefore leave the actual fulfillment of his prescribed treatment to others less skilled. If this were not the accepted practice, no person of moderate means could afford to employ either a specialist or general practitioner. The Court then pointed out that a patient enters a hospital relying upon the reasonable assumption that the trained staff of nurses and the equipment used will insure a high standard of care according to the prescription of the physician.

Differentiation

The Court makes a basic differentiation between the acts of nurses and other employees for which a hospital is liable as administrative or clerical acts and acts for which the hospital has no liability as

those which require an exercise of medical skill or judgment. Whether an act is merely administrative, so that negligence in its performance is imputed to the hospital, or nonadministrative depends on the nature or character of the act.

The Georgia Court of Appeals decided in the facts of the particular case that hospital employees in preparing the incubator to receive the baby, in preheating the incubator with an electric light bulb and in placing the baby in the incubator and strapping her down were performing merely administrative or clerical acts which involved the application of no specialized technique or understanding of a skilled physician or surgeon. Since the acts were not performed under the immediate personal supervision of the defendant surgeon but were performed in his absence and were merely routine acts within the scope of the duties of hospital employees in carrying out the prescription of the doctor, the acts were not imputed to the surgeon but were the acts of the hospital for which it and not the surgeon was responsible.

Similar Cases

The Court of Appeals went on to follow holdings by the Supreme Court of Minnesota and by the Court of Appeals of Louisiana in similar cases to the effect that the patient was entrusted by the physician to the care of hospital employees whose

regular duty was to prepare the patient for a contemplated operation. The preparation by the hospital employees did not involve the application of specialized medical knowledge or skill. The physician was entitled to rely upon the reasonable assumption that the hospital employees carried out their duties without negligence in the absence of some fact or circumstances putting the physician on notice that the duties had been negligently performed.

Decision Is Desirable

The decision of the Georgia Court of Appeals appears to be extremely desirable. A contrary decision would have theoretically put upon the surgeon ever widening responsibility which would have diverted his attention from the exercise of his particularly expert abilities. It makes no sense to require a surgeon to be responsible to check on the sterility of instruments, the proper placement of the patient in the incubator, or other administrative details which should normally be handled in proper fashion by other persons pursuant to the doctor's prescription. Thus, the doctor in Georgia, unless this case is overturned, can still focus his attention on the aspects of his work which he and he alone can perform.

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Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.

EMORY TO ESTABLISH DEPARTMENT OF BIOMETRY

Emory University has recently announced plans for a department of biometry in its medical school.

New Head

Dr. Malcolm E. Turner, Jr., currently chairman of the Division of Biometry, Medical College of Virginia, will come in July, 1963, to head Emory's new department.

Research and Teaching

Dean Arthur P. Richardson of the medical school said the new department will develop the application of mathematics to research and teaching in the field of medicine at Emory.

Dr. Turner will later develop a graduate program in

biometry in Emory's graduate school, Dean Richardson said.

Computer

Emory's new computer center in the school of business will be of great value to the department of biometry, the dean added.

Atlanta Native

A native of Atlanta, Dr. Turner received his B.A. at Duke, and his M.E.S. and Ph.D. degrees at North Carolina State.

He was analytical statistician for the Communicable Disease Center in Atlanta and later assistant professor, at the University of Cincinnati Medical School, before going to the Medical College of Virginia.



LEARNING PROBLEMS IN ADOLESCENTS

Jerome D. Oremland, M.D., *San Francisco, California*

THIS WILL BE A DISCUSSION of a particularly unfortunate way in which an adolescent might manifest psychologic conflict and unhappiness. The sort of learning disability to be considered is disturbance in learning as an expression of the frustration, inner tension, depression, and alterations in self concept which are so a part of the adolescent process.

Such a disturbance may be highly specific—so specific as to include only a particular subject matter, say mathematics, or so highly diffuse that there is a lack of emotional involvement in any of life's activities. The disturbance can be acute, with a sudden loss of interest in what one is doing, or can be more insidious with a gradually increasing lack of ability to involve one's self. The disturbance may be transitory, with what appears to be almost spontaneous remission, or there can be a relentless downward progression resulting in a certain series of failures so that the whole life's course must be altered and limited by what has taken place. In other words, we must differentiate between specific resistance to learning, and general apathy.

Low Achievement

Another highly important learning disability is low achievement. Here are young people with above average endowment who do average or less than average work. They produce a state of academic anonymousness—a state in which they escape notice by not failing, and escape being made responsible by not being outstanding.

Specific learning disability, that is the development of an inability to take in or assimilate material, may be related to conflicts about curiosity and inhibitions toward exploring. Conflicts about seeing new things, or about having to display oneself may result in a clamping down of the intellectual ap-

paratus. New ideas and unfamiliar methods are shunned, and there is a slavish attempt to remain on familiar ground and in familiar areas. It is somewhat analogous to the hysterical scotomata, in that whole blocks of information must be disregarded, passed over, and not acknowledged.

Sex Role Problems

Low achievement, at times, arises out of problems about the sex role. A girl with a shaky feminine image may feel that brains will be considered unfeminine, and utilizes low achievement as a way of assuring acceptance. Likewise, a boy with a shaky masculine self-image may attempt to use low achievement as a way of gaining peer approval, or at least not risking losing friends by being the brain. At times, low achievement arises out of a reaction formation against the aggressive component of competition. It becomes a way of hiding destructive and hostile feelings behind a veneer of kindliness, consideration, and unobtrusiveness.

An important factor in low achievement may be the situation of fear of putting forth the maximal effort and testing ability—an attempt to maintain a phantasy that, "if I had only tried, I would have been able." At times this arises when the parental expectation is very high, and seems to be the condition for acceptance. The adolescent, by low achieving, though eliciting parental anger and punishment, escapes the threatened loss of love that he fears should they or he find out that his ability is not as he feels they need and expect. I think you see this, almost invariably, when the parents exaggerate the accomplishments of their child—thereby indicating to the child that the accomplishment as actually done is not acceptable or enough.

Low achievement may, of course, be a direct at-

tempt of the adolescent to thwart parental ambitions, as part of the emancipation storm that often takes place during the adolescent years. Assuming an attitude in opposition to the parents is felt to be a type of independence, even though the slavish negativism is so apparent to the observer.

Self-Punishment

Low achievement may be part of a general self-punishment for conscious and unconscious feelings of guilt and low self-esteem. Feelings of not deserving abound; with any success, there is anxiety and guilt—relief comes through failure.

Apathy in adolescence is a particularly ominous way of dealing with conflict. The change from the illusionary omnipotence of childhood to the reality of the adult situation often is bridged by an attempt to change the attitudes of the adult world. Sometimes, the bridge is made by a zealous attempt to understand the world and the nature of things. In this we may see an increased desire to learn. There may be an intensive, zealous study of religion, philosophy, and natural science. Here we see learning utilized as a defense. For some though, the change brings despair. Should the situation be such that meaningful experiences and people are not forthcoming, this despair, which may be very acute, can turn into apathy—a state of, “what does it matter.” Life’s pursuits are seen as empty, meaningless, and inane; emotional ties are broken; and as the emotional investment is withdrawn, people seem to become pup-

pets going through the task of living. Tradition is seen as shallow and unimportant. There may be passive hostility, a flaunting of authority in the sense of, “show me why I should care,” or, “make me interested.” As this feeling deepens, a sense of unreality and phoniness ensues. Time seems to stand still, or rush by, and we see the ego falling apart. Defenses become brittle and impulses are near the surface. Panic ensues, and the individual feels very alone in a false and antagonistic world. Everywhere he turns for help seems hopeless, for none can give what he wants.

Sometimes the process is less acute and less dramatic, and we see a more smoldering passive hostility. A person with little in the way of interest, much in the way of negativism, balkiness, and lethargy—a person who must dampen the enthusiasm for others. Ofttimes, this takes the form of a pessimism which is covered by what is termed realism.

Summary

I have attempted in this brief sketch to differentiate specific learning disabilities, low achievement, and apathy. I have attempted to illustrate some of the dynamics of these states. Each we see as the snow-balling effect of the preceding distorted experience. The specifics of the development of each, of course, can only come from the developmental understanding of the personality involved.

3003 Fillmore at Union Street

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

**“REALISTIC NAME
FOR MEDICARE”**

Many physicians have long considered the term “socialized medicine” as a vague euphemism for a very real danger. Now the California Academy of General Practice has resolved to drop the term altogether in favor of “a more suitable descriptive term.”

Invasion and Control

Pointing out that “government invasion of the practice of medicine is invariably associated with some phase of government control,” the Academy counsels use of such terms as:

- *Government-controlled medicine*
- *Politically-dominated medicine*

These terms, the resolution asserts, “will explain the undesirable feature of meddlesome government control of the practice of medicine.”

Slogans Stick

When Administration leaders came up with “medicare,” they fully realized that slogans have a way of sticking in the mind and influencing human behavior. Such terms as those devised by the California Academy can do much to inform the public on the realities of government medicine and also to counter Administration sloganeering.



Copeland, Elton L., M.D., and Robert F. Mabon, M.D., Toccoa Clinic, Toccoa, Georgia, "Spontaneous Intracranial Bleeding in Pregnancy," *Obst. & Gynec.* 20:373-378 (Sept.) 1962.

Due to the increasing incidence of spontaneous subarachnoid hemorrhage secondary to aneurysm, attention is being focused on this problem occurring in other conditions, particularly during pregnancy. Six previously unreported instances of spontaneous subarachnoid bleeding occurring during pregnancy are discussed in detail with four resulting maternal deaths, representing 80 per cent of all maternal deaths in 11,196 deliveries at St. Joseph's Infirmary during the six-year period from 1955-1961. This brings the total number of reported cases of subarachnoid hemorrhage in pregnancy to 104.

A detailed discussion of the diagnosis, etiology, and management of this problem during pregnancy is presented.

This disorder occurring during pregnancy should be treated in the same fashion as in the general population, unless onset of labor is imminent. This complication of pregnancy should always be entertained in atypical cases of eclampsia.

Evidence is cited that would indicate vaginal delivery to be as safe as or safer than caesarean section.

Schlant, Robert C., M.D.; Tsagaris, Theofilos J., M.D.; Robertson, Robert J., Jr., M.D.; Winter, Thorne S., III., M.D., and Edwards, F. Kathryn, M.D., Emory Hospital, Atlanta 22, Georgia, "The Effect of Acetylcholine Upon Arterial Saturation," *Am. Heart J.* 64:512-524 (Oct.) 1962.

1. Infusion of acetylcholine into the pulmonary artery or right ventricular outflow tract in a dose of 1.6 to 4.0 mg. per minute (20 to 75 μ g per minute per kilogram) in the patients studied was associated with the following changes: (a) a decrease in mean arterial saturation; (b) an increase in mean cardiac index and a decrease in mean calculated total pulmonary resistance and total systemic resistance but no significant change in mean pulmonary arterial pressure, mean brachial arterial pressure, or mean pulse rate; (c) a slight increase in minute ventilation, with no significant change in mean oxygen consumption or respiratory exchange ratio and no statistically significant increase in mean ventilation equivalent.

2. Inhalation by the patient of 99.6 per cent oxygen for five minutes while acetylcholine was being infused reversed the arterial unsaturation produced by the infusion of acetylcholine, but five or ten-minute period of breathing oxygen during the infusion of acetylcholine did not usually produce a full 100 per cent oxygen saturation of arterial hemoglobin.

3. The mechanism of the systemic arterial oxygen unsaturation produced by acetylcholine is discussed, and it is assumed that acetylcholine produces arterial unsaturation by decreasing the protective local vasoconstriction which is thought to occur normally in areas of the lung which are poorly ventilated.

Vaughan, V. C., III., M.D.; Dienst, R. B., Ph.D.; Sheffield, C. R., B.S.; and Roberts, R. W., A.B., Medical College of Georgia, Augusta, Georgia, "A Study of Techniques of Preparation of Formulas for Infant Feedings," *J. Pediat.* 61:547-555 (Oct.) 1962.

"A study of methods of preparation of formulas for infant feeding in Augusta, Georgia, disclosed that few mothers were following the procedure (terminal sterilization) recommended in the Well-Baby Clinics which they attended. Home visits with bacteriologic cultures of various surfaces suggested that heavy growth of organisms was more likely to be found under conditions of generally poor housekeeping and in relation to surfaces commonly involved in the method of preparation of formula most widely used in the community. Few homes were equipped to carry out terminal sterilization. It seems possible that a bottle-at-a-time method, using tap water and evaporated milk, may be safely used in a community where: (1) an adequate public water supply exists, (2) the likelihood of contact with enteric pathogens appears low, and (3) the quality of communication and education is generally sufficient to lead to adequate understanding of and reasonable care in use of the method. The need for study of what mothers actually do in preparation of formulas for infant feeding is emphasized. Other problems needing further study are discussed."

Findley, Thomas, M.D., Medical College of Georgia, Augusta, Georgia, "The Resident, the Graduate School, and the Specialty Board," *JAMA* 182:926-928 (Dec.) 1962.

The phenomenal growth of residency training programs in the past thirty years is contrasted with the relatively stable number of medical students graduated each year. The demand for post-graduate training is largely due to the various specialty boards and hospital training has become the most important part of the education of approximately 80 per cent of our medical graduates. It seems high time that residents be recognized as the graduate students they really are, and that the various medical schools assume more formal responsibility for their welfare. Medical schools could be of enormous help to the examining boards in an advisory capacity. If the residents did three months of didactic work each year much of the material now crowded into the undergraduate program could be

taught at the graduate level. Educational standards for specialists already demand an eight to ten year curriculum.

Hughston, J. C., M.D.; Whatley, George S., M.D.; and Stone, Mario M., M.D., Physicians Building, Columbus, Georgia, "Myositis Ossificans Traumatica (Myo-Osteosis)," *South. M.J.* 55:1167-1170 (Nov.) 1962.

This is a clinical review of 32 cases of myositis ossificans traumatica treated by the authors. The cases were studied relative to their symptoms and signs, the course of the disorder, the effect of conservative treatment on the course and results, the stages of radiographic changes, and pathological findings at surgery.

The clinical picture was one of unresolved "Charley Horse" in an adolescent male engaged in contact sports. Early recognition and treatment by rest of the extremity most frequently produced resorption of the calcification. Operative removal of the mature mass was performed in those cases where the mass was quite large, was projecting, was predisposed to further injury, or where it limited juxtapositional joint motion. No operative complications occurred.

Wilds, Preston Lea, M.D., Medical College of Georgia, Augusta, Georgia, "Is Colposcopy Practical?" *Obstet. & Gynec.* 20:645-650 (Nov.) 1962.

A comparative study of 610 cytologic and 779 colposcopic examinations in 511 obstetric and gynecologic patients resulted in the detection of nine preinvasive cancers of the cervix by cytologic methods. Six failures of the colposcopic method were attributed to (1) inaccessibility of the endocervical canal to direct inspection and (2) insufficient use of the punch biopsy. Colposcopic indications for biopsy, although an improvement over the Schiller test and random punch biopsy, were much less specific than cytologic indications in detecting preclinical cancer. The colposcope does not seem to offer a practical way to compensate for the known deficiencies of cytologic screening.

Ketcham, Alfred S., M.D., Bethesda, Md., and Smith, Robert R., M.D., 1364 Clifton Rd., N.E., Atlanta 22, Ga. "Elective Esophagostomy," *Am. J. Surg.* 104:682-685 (Nov.) 1962.

Nasogastric tube feeding may be necessary during extended convalescence following surgical and/or radiation therapy for oral, pharyngeal or laryngeal cancers. Prolonged use of this tube is not satisfactory and may result in pressure necrosis of the pharyngeal esophageal wall at the level of the cricopharyngeus. An alternative to nasogastric gavage has been a gastrostomy. This method of

feeding is usually not satisfying to the patient. It requires the patient to partially undress before feeding himself and in most instances he must lie in a supine position after feeding to prevent leakage.

In 1951, Klopp described the procedure of cervical esophagostomy. This procedure was found of great value in the clinical management of 168 head and neck cancers treated at the Clinic Center of the National Institutes of Health. It consists of producing an esophageal cutaneous fistula at the level of the medial end of the clavicle. The lateral esophageal wall is isolated and a Levin tube passed through the wall into the stomach. The opening in the esophagus is closed around the Levin tube with a purse string suture and the tube brought out with a Penrose drain through the lower end of the skin incision.

Complications following this operation have been infrequent. The greatest danger during the surgery is the possible traumatizing of the recurrent laryngeal nerve. The feeding tube can be changed, for cleaning purposes, any time after ten days and has been left in place for as long as five and one half years. In the usual instance it is removed when swallowing function returns to normal and the fistula heals without difficulty.

Yeh, Thomas J., M.D.; Ellison, Lois T., M.D., and Ellison, Robert G., M.D., Medical College of Georgia, Augusta, Georgia, "Functional Evaluation of the Autotransplanted Lung in the Dog," *Am. Rev. Resp. Dis.* 86:791-797 (Dec.) 1962.

Replacement of a diseased vital organ with a healthy one has long been a challenge to surgeons. Homologous lung transplantation may become possible in the future when the mechanism responsible for homograft rejection can be suppressed with artificial means. Successful autotransplantation is a necessary intermediate step toward this goal. The purpose of this study is to evaluate the function of the autotransplanted lung in the dog.

SUMMARY

Thirty-three dogs were subjected to lung autotransplantation. Systemic heparinization was used in 21 dogs, and 16 were long-term survivors. Respiratory function studies in nine dogs showed ventilation to be unaltered but blood oxygenation significantly impaired. Pulmonary artery pressure was within normal limits in all dogs. Upon balloon occlusion of the contralateral pulmonary artery, pulmonary hypertension developed in three dogs. Respiratory studies performed on one dog that survived contralateral pneumonectomy for 13 days suggest that function of the autotransplanted lung is sufficient to sustain life. Causes of death following contralateral pneumonectomy seem to lie in bronchial complications which, with further experience, possibly can be prevented.

Prince, C. L., M.D., and Scardino, P. L., M.D., 2515 Habersham St., Savannah, Georgia, "Newer Diuretic Evaluations for Obstetric and Gynecologic Conditions," *Jour. of La. State Med. Society*, 113:314-320 (Aug.) 61.

The clinician is now faced with the problem of choosing and selecting the diuretic agent that will best fulfill the therapeutic needs of the patient. A classification of diuretics used in Obstetrics and Gynecology are enumerated as to the group of drugs, route of administration and electrolytes excreted. A list of the currently available benzothiadiazine group of diuretics is enumerated as to their trade name, generic name and tablet size. A summary is also given as to their response, potency and side effects.

An attempt is made to outline how a diuretic agent can be evaluated in relation to the drug and placebo medication. This evaluation is further reinforced by balance ward studies in reference to the sodium and potassium output as well as urine output and weight loss. A new diuretic agent SU-8341 (Navidrix®—Ciba) is evaluated.

It is necessary to know the response of a placebo medication, low salt diet, and bedrest before a diuretic agent can be evaluated as to its efficacy. Balance

ward studies are needed in the evaluation of newer diuretics.

Prince, C. L., M.D., and Scardino, P. L., M.D., 2515 Habersham St., Savannah, Georgia, "Variable Salt-Loading During Pregnancy With Preeclampsia," *Ob, and Gyn.* 18:530-534 (Nov.) 1961

Three surgical techniques, namely, Y-plasty, intubated ureterotomy and pelvic flap ureteropelvioplasty were subjected to critical evaluation. From the analysis of the 82 cases, it was found that revision of obstruction due to high ureteral insertion is best accomplished by the Y-plasty. If there is dependent ureteral obstruction, that is obstruction at the most dependent portion of the ureter (low ureteral insertion), revision is best accomplished by use of a flap of viable renal pelvic tissue provided by vertical flap ureteropelvioplasty. If the obstructed area is too far distant from the renal pelvis to permit use of a pelvic flap, intubated ureterotomy offers the best results.

An evaluation of the three techniques rests on the degree of relief of symptoms, return of the kidney to normal both functionally and structurally as well as the absence of infected urine after a reasonable period of observation. Of the 82 procedures, ten could not be adequately followed. Of these adequately analyzed, approximately 12 per cent were surgical failures, but only nine per cent of the total number required secondary nephrectomy. Statistically 62 per cent were classified as good surgical results while 25 per cent left something to be desired.

Neither existent infection nor calculi contributed significantly to the result. However, postoperative calculus formation was the most common complication regardless of the technique employed. This observation has contributed in no small part to the author's determination to avoid splinting the area of pathology. An effort is made to divert the urinary flow proximal to the area of repair by producing a small window in the renal pelvis to allow the urine to escape prior to its traversing the area of repair.

HEALTH SERVICE RECOMMENDS POLIO VACCINE

The Public Health Service recommended use of type III Sabin oral polio vaccine after having banned it for three months while its safety was being reviewed. But the PHS still recommended that older adults take it only if their risk of catching the disease is higher than normal.

Surgeon General Luther L. Terry acted upon the recommendation of his special polio advisory committee. Dr. Terry urged that communities use all three types of the Sabin vaccine in polio immunization campaigns with particular emphasis on children and young

adults.

The advisory committee said:

"Because the need for immunization diminishes with advancing age and because potential risks of vaccine are believed by some to exist in adults, especially above the age of 30, vaccination should be used for adults only with the full recognition of its very small risks."

The PHS reported that polio continued to decline last year. There was a drop of 35 per cent from 1961 in the number of cases. There were 866 cases, including 707 paralytic, reported through November 30, 1963.

THE ASSOCIATION



DEATHS

NATHAN M. DeVAUGHN, SR., 46, of Augusta, died December 12, 1962, of a heart attack in a local hospital. Dr. DeVaughn was buried at Montezuma.

He was a member of the Richmond County Medical Society, the Medical Association of Georgia, the American Medical Association, the American Diabetic Association, the American Heart Association, Alpha Omega Alpha, honorary medical fraternity, and Phi Rho Sigma, national medical fraternity.

Survivors include his wife, Mrs. Margaret K. De Vaughn; two daughters, Mrs. Margaret Ann Reese and Miss Carla Lou DeVaughn, and one son, Nathan M. DeVaughn, Jr., all of Augusta, and two brothers, J. E. DeVaughn, Montezuma, and R. W. DeVaughn, New York, N. Y.

SOCIETIES

George W. Mixon, Ocilla, was recently elected president of the BEN HILL-IRWIN MEDICAL SOCIETY. Elected to serve with him for the coming year were Morgan Smith, vice president; and Ralph Roberts, secretary-treasurer. Named as delegates to the AMA meeting were J. C. Smith and alternate, Ralph Roberts.

Braswell Collins of Macon was elected president of the BIBB COUNTY MEDICAL SOCIETY December 4, 1962. Other officers are E. C. McMillan, president-elect; W. Earl Lewis, vice president; John T. Dupree, secretary; Milford B. Hatcher, parliamentarian; Ralph G. Newton, Jr., and Waddell Barnes, delegates to MAG; and Milledge Newton, and John O'Shaughnessey, alternates. Elected to the executive committee were Rudolph Jones and Z. S. Sikes. George Alexander and W. H. M. Weaver were elected councils to MAG, and W. M. Pound was selected as representative to the Macon-Bibb County Board of Health.

Thomas J. Anderson, Jr., Atlanta, is the new president-elect of the FULTON COUNTY MEDICAL SOCIETY. Installed January 3, 1962, in Atlanta as the new president of the society was R. Carter Davis. Other new officers include J. Frank Harris, vice president; William Moore, secretary-treasurer; Joe Girardeau, judicial council chairman; Haywood N. Hill, senior board member; Charles B. Upshaw, Jr., junior board member; J. G. McDaniel, councilor to the Medical Association of Georgia, and Charles S. Jones, vice councilor.

"Food Without Fear," was the subject of the talk given by Mr. W. W. Bauer, Director of Health Education, Emeritus of AMA, at the January 8, 1963, meeting of the GEORGIA MEDICAL SOCIETY held in Savannah.

P. K. Dixon, Gainsville, is the new president of HALL

COUNTY MEDICAL SOCIETY. Also elected at the December meeting held in Gainsville were Hamil Murray, vice president; and Clark Ferrell, secretary-treasurer.

PARVIEW MEDICAL SOCIETY met December 12, 1962, at Macon to elect officers for 1963. Serving as president is Jasper Hogan; as vice president, E. C. McMillan; and as secretary, Raymond Moody.

Edwin W. Allen, Jr., Milledgeville, is the new president of the SIXTH DISTRICT MEDICAL SOCIETY. Serving with him in 1963 will be Mark Watkins, Dublin, vice president; and Hugh Sealy, Macon, secretary treasurer.

William Anderson of Americus has been elected president of the SUMTER COUNTY MEDICAL SOCIETY. Re-elected vice president was Frank Castellow, and Harvey Simpson was named secretary-treasurer.

PERSONALS

First District

FRANKLIN P. BOUSQUET, Savannah, has been chosen chief of staff of Memorial Hospital of Chatham County. Dr. Bousquet assumed his duties January 1, 1963. Other officers elected were president-elect E. G. EDWARDS, JR., and secretary-treasurer, DAVID E. TANNER.

Section Chiefs for 1963 are: Surgery, J. L. ALEXANDER; medicine, MURRAY C. ARKIN; urology, PETER L. SCARDINO; ob-gyn., LONNIE R. LANIER; eye, ear, nose, throat, J. L. REEVES; pediatrics, CARL H. BRENNAN; pathology, CARLOS JARAMILLO; radiology, DAVID E. TANNER; general practice MELVIN BERLIN; anesthesiology, R. L. STONE; dental, DUANE DeVORE.

IRVING A. VICTOR, Savannah, was elected president of the Warren A. Candler Hospital staff December 20, 1962. Earlier in December Dr. Victor was elected president of the Oglethorpe Sanatorium staff.

WILLIAM H. LIPPITT was elected president-elect of Candler's staff. Re-elected for a second term were DEARING A. NASH as secretary and CHARLES SAX as treasurer.

Re-elected as department chiefs were FENWICK T. NICHOLS, department of medicine, and T. A. GRANT, department of dentistry.

Newly elected department heads are HARVEY MORGAN, department of general practice; JULIAN K. QUATTLEBAUM, JR., department of surgery, and LOUIS P. LEOPOLD, department of obstetrics and gynecology.

RUTH WARING was elected vice president of the staff

of Oglethorpe Sanatorium and HOLLIS E. PUCKETT, was elected secretary.

ROBERT M. HOWARD, Savannah, has joined his brother, LEE HOWARD, JR. in the practice of pathology at the Howard Clinical Laboratories in Savannah.

MASON G. ROBERTSON, Savannah, was named as an associate of the American College of Physicians December 14, 1962.

Second District

No news submitted.

Third District

Dawson physician, WILLIAM H. BRIDGES spoke to the Dawson Rotary Club December 12, 1962. Dr. Bridges spoke on some of his experiences as a student at the Medical College of Georgia from which he received his medical degree in 1958.

At its monthly meeting December 4, 1962, the medical staff of Peach County Hospital, Fort Valley, elected DANIEL E. NATHAN as chief of staff; FRANK VINSON will serve as assistant chief of staff. V. F. McFALL, Robins Air Force Base, was appointed chairman of the committee on records and accreditation, and JOHN ARNALL, Perry, was named to serve with Dr. McFall. L. H. CAMPBELL, Macon, was appointed chairman of the tissue committee, and serving with him will be E. F. SEAY, Marshallville, and V. J. GRANTHAM and A. S. MARSHALL, Fort Valley.

The medical staff of the Americus and Sumter County Hospital has elected HENRY R. FENN, of Americus, as president for the coming year. Others elected included BON DURHAM, as vice president, and FRED THOMPSON was re-elected secretary-treasurer.

Fourth District

No news submitted.

Fifth District

WILLIAM W. MOORE, Atlanta, was recently appointed chairman of the Northside Y.M.C.A. membership enrollment. Dr. Moore has been an active member of the Northside Branch Board of Management for five years and has served as vice chairman of the enrollment drive.

President of the Georgia Psychiatric Board, SIDNEY ISENBERG, Atlanta, was guest speaker December 7, 1962, for the Board of Directors' luncheon of the Georgia Association for Mental Health held at the Atlanta Americana Motor Hotel.

The addition of THOMAS B. SHARP, Atlanta radiologist, to the staff of Laurens Memorial Hospital, Dublin, was announced December 15, 1962. Dr. Sharp will join GRADY CAMPBELL, Dublin, a previous member of the staff.

An article by CRAWFORD BARNETT, JR., Atlanta, was featured in the sixth annual Christmas issue of the *Georgia Magazine*. Dr. Barnett is the great grandson of Georgia's Civil War-time governor, Joseph E. Brown, and his contribution concerned the early life of Governor Brown.

SHIRLEY L. RIVERS, Atlanta, attended the Acute Leukemia Task Force Meeting in Bethesda, Maryland, November 14, 1962, and the American Society of Hematology Meeting in Columbus, Ohio, on November 26, 1962.

Sixth District

A. C. MARTINEZ, a senior physician in internal medicine at Milledgeville State Hospital for more than six years, has entered private practice in Milledgeville as an associate of EDWIN W. ALLEN, JR.

Seventh District

The Floyd W. McRae Surgical Society held its inaugural banquet November 28, 1962, at the Piedmont Driving Club in Atlanta. Presiding over the affair was T. E. REEVE, JR., of Carrollton, president of the society. ALTON OCHSNER of the Ochsner Clinic in New Orleans was the speaker of the evening.

Eighth District

No news submitted.

Ninth District

W. BRUCE SCHAEFER, Toccoa, attended a seminar on Orthopaedic Surgery at the New York University Medical Center in New York City during the second week in December.

Tenth District

THOMAS W. GOODWIN, Augusta, announced the resumption of his practice January 2, 1963.

CAROL PRYOR, Augusta, spoke on, "Admission Requirements to Medical Schools," at the December meeting of Richmond Academy's Allied Medical Careers Club December 13, 1962, at the school.

EXECUTIVE COMMITTEE OF COUNCIL MEETING

THE EXECUTIVE COMMITTEE of Council of the Medical Association of Georgia was called to order by President Thomas W. Goodwin at 11:05 A.M., on December 8, 1962, at the Holiday Inn, Albany, Georgia.

Those in attendance at the meeting were Thomas W. Goodwin, Augusta; John T. Mauldin, Atlanta; George H. Alexander, Forsyth; J. G. McDaniel, Atlanta; George R. Dillinger, Thomasville; Lee H. Battle, Rome; Fred H. Simonton, Chickamauga; and John S. Atwater, Atlanta. Mr. Richard Nelson, AMA Field Representative was present and the staff members present were Mr. M. D. Krueger, Mr. James Moffett and Mrs. Catherine Wooten.

Reading of Minutes

Mr. Krueger read the minutes of the November 4 and 8, 1962, meeting of the Executive Committee. There being no corrections the minutes were approved as read.

Medicare Contract Renewal

Mr. Krueger stated that the contract was brought to the Executive Committee for recommendation to Council that it be renewed, there being no changes in the contract. On motion duly made and seconded it was voted to recommend to Council that the Medicare contract be renewed.

Special Projects Meeting

President Goodwin suggested that a possible date for the Special Projects Meeting would be January 19-20, 1963, in Atlanta. Doctors McDaniel and Mauldin were instructed to arrange the site and time of the meeting. Executive Committee is to meet at the same time.

THE ASSOCIATION / Continued

Headquarters Office Personnel

President Goodwin stated that in his opinion another Headquarters staff man was necessary due to increased membership and work load. After discussion it was decided to ask Dr. McDaniel, Chairman of Finance, to get Council approval for the employment of a third staff man.

Release of Hospital Information Instruction Sheet by Georgia Hospital Association

The Georgia Hospital Association requested approval by the Medical Association of Georgia of information which they desire to use as a guide in releasing information to the newspapers on hospital admissions. Mr. Krueger stated that the MAG Hospital Relations Sub-Committee had recommended that the name of the Medical Association of Georgia not appear on the completed placards to be posted in various hospitals. After discussion, on motion duly made and seconded it was voted that the Medical Association of Georgia approves in principle the information to be disseminated provided that consent be obtained from the patient, or the patient's representative, when possible, for the releasing of this information, and if not possible, to obtain the information from the attending physician. The Georgia Hospital Association is to be notified of this action and the suggestions of Dr. Hatcher and Mr. John Moore, MAG Attorney, in the rewording of some of the sixteen items submitted by G.H.A. organization for consideration by MAG.

Old Business

(1) Kerr-Mills Progress Report—Dr. Mauldin reported that the Kerr-Mills program had progressed well in 1962. With the increased work load he stated that there was need for a filing cabinet and dictating equipment. On motion (Simonton-Alexander) it was voted to ask the Welfare Department to purchase and pay for this equipment with the understanding that if the contract should be terminated, the MAG would have to pay the undepreciated balance. Dr. Mauldin also stated that another part-time employee would be needed and would be employed the first of 1963.

(2) Georgia Psychiatrist Association President's Letter—Mr. Krueger read a letter which had been sent to Dr. Dillinger, asking that the appointment to the MAG Mental Health Sub-Committee be made from the past presidents of the Georgia Psychiatric Association. This letter was received for information.

(3) Georgia Hospital Association Request—Drs. Goodwin and Mauldin were invited to be guest speakers at the Georgia Hospital Association 1963 convention, February 28-March 1, DeSoto Hotel, Savannah. The Executive Secretary was instructed to inform the Georgia Hospital Association that Drs. Goodwin and Mauldin will accept the GHA invitation to be on their program.

New Business

(1) Medical Reserve Officer as Liaison to State Medical Association—A letter from the AMA Department of National Security requesting the appointment of a medical reserve officer in each state as liaison officer to the state medical association was read. This was received for information.

(2) Maltreatment of Children Letter—A letter was read regarding enactment of a law making mandatory the reporting of suspicious cases of maltreatment of children. On motion duly made and seconded it was voted that there was no objection to such legislation but the Executive Committee would like to review such legislation before it is introduced.

(3) Interprofessional Council Member Reappointment—It had been brought to the attention of MAG Headquarters office that Dr. William A. Wood's appointment to the Interprofessional Council was expiring and it was necessary to reappoint him or another member. On motion (McDaniel-Dillinger) it was voted to reappoint Dr. William A. Wood to the Interprofessional Council.

There being no further business the meeting was adjourned at 12:35 P.M.

MEDICAL ASSOCIATION OF GEORGIA COUNCIL MEETING

THE REGULAR QUARTERLY meeting of Council was called to order at 2:10 P.M., December 8, 1962, Holiday Inn, Albany, Georgia.

The invocation was given by Dr. John S. Atwater.

Council members attending this meeting were: Thomas W. Goodwin, Augusta; George R. Dillinger, Thomasville; Fred H. Simonton, Chickamauga; Lee H. Battle, Rome; Walker L. Curtis, College Park; George H. Alexander, Forsyth; John T. Mauldin, Atlanta; John S. Atwater, Atlanta; Joseph B. Mercer, Brunswick; Charles Bohler, Brooklet; W. Frank McKemie, Albany; Frank Wilson, Leslie; Virgil Williams, Griffin; Floyd Sanders, Decatur; Ralph N. Johnson, Rome; F. G. Eldridge, Valdosta; C. R. Andrews, Canton; J. C. Brim, Pelham; C. T. Cowart, LaGrange; J. W. Yeomans, Jesup; P. T. Scoggins, Commerce; M. A. Hubert, Atlanta; Walter Brown, Savannah; H. D. Pinson, Augusta; J. G. McDaniel, Atlanta; J. L. Mulherin, Augusta; Luther H. Wolff, Columbus; J. W. Chambers, LaGrange; and Eustace A. Allen, Atlanta. Others present at the meeting were: Mr. Francis Shackelford and Mr. John Moore, MAG Attorneys; Mr. Richard Nelson and Dr. Paul McCleave, AMA, Chicago; Linton H. Bishop, Atlanta; Milford B. Hatcher, Macon; David R. Thomas, Augusta; and Frank T. Robbins, St. Mary's. Staff members present were Mr. M. D. Krueger, Mr. James M. Moffett, Mr. James Baker, and Mrs. Catherine Wooten.

Reading of Minutes

Mr. Krueger read the minutes of the September 8-9 Council meeting; and of the Executive Committee of September 9, October 11, November 4 and 8, 1962. There being no corrections, the minutes were approved as read.

Treasurer's Report

Dr. Atwater reviewed the Treasurer's Report and upon motion duly made and seconded the report was approved as read.

Report of Finance Committee

Dr. McDaniel, Chairman of Finance, reported on:

(a) 1963 Proposed Budget: On motion duly made and seconded it was voted to accept the 1963 budget as proposed.

(b) MAG President's Honorarium: It was recommended that one-half of the honorarium should be paid after the first six months of his term of office and one-half at the conclusion of the second half of his term of office; or in lump sum at the discretion of the President. Council voted to approve this recommendation.

(c) MAG Employees Pension Plan: Deferred.

(d) Employment of Staff Man: After discussion about the employment of a third staff man, on motion (Wolff-Bohler) it was voted to ask the Executive Committee to make recommendations regarding employment, salary, etc., at the March Council meeting.

At this point in the meeting Chairman Alexander read a telegram from Dr. William Rawlings, 6th District Councilor, expressing regret that he could not be present at this meeting.

MAG Civil Suit Re Membership

Mr. Shackelford, MAG Attorney, discussed the civil suit now pending regarding non-discrimination and membership in county medical society and state medical association. He stated that the MAG attorneys have filed a motion to dismiss. This report was received for information.

"Family Responsibility" Bill Proposal

President Goodwin gave background information on the "Family Responsibility" bill proposal and the actions of the MAG Executive Committee in this regard. Mr. Shackelford explained the agreement that had been worked out that would consist of the rendering of a single bill based on a per diem rate for professional services to simplify billing for the State Department of Health, and a contract agreement between the physicians themselves to insure that the fees collected for their services were donated for research purposes. After discussion on this subject, on motion (Goodwin-Wolff) it was voted to approve the agreement.

Extension of Professional Liability Insurance

Dr. Wolff stated that this had to do with coverage of an individual's acts or omissions while serving as an officer, committee or board member of any organized medical group. An insurance company policy, about which he knew, did cover

individuals in the above capacity, and to the best of his knowledge the St. Paul policy did not. He asked if the St. Paul Company would include this coverage in their policy. It was suggested that the Secretary be authorized to obtain this information from the St. Paul Company. Therefore, on motion (Wolff-McDaniel) it was voted that the Secretary be instructed to investigate the possibility of inclusion of the above coverage in the St Paul policy, and report back to Council.

Constitution and Bylaws Board Report

Dr. Mulherin reported for Chairman W. G. Elliott, who could not be present, on the meeting of the Constitution and Bylaws Board held October 26, 1962, regarding:

(a) Medical Defense Committee—This committee formerly was carried in the MAG Constitution and Bylaws, but was deleted in the reorganization of MAG Boards and Committees. The duties of this committee had guaranteed any member whose case was deemed worthy of defense \$100.00 advice from the Association Attorney for any one case in any one calendar year. The Constitution and Bylaws Board recommend that the Medical Defense Committee should be reinserted in the Constitution and Bylaws to be known as the Sub-Committee on Medical Defense. After discussion, on motion (Wolff-McDaniel) it was voted that the Council request that this be brought before the MAG House of Delegates without recommendation.

(b) First Vice President—The MAG House of Delegates had recommended that the suggestion that the First Vice President be made a voting member of the Executive Committee of Council be referred to the Constitution and Bylaws Board for consideration and further action. The Constitution and Bylaws Board recommended that the First Vice President be made a full voting member of the Executive Committee of Council. On motion duly made and seconded it was voted that Council should refer this matter to the MAG House of Delegates with the recommendation that it be approved.

(c) Second Vice President—It was recommended by the Constitution and Bylaws Board that Chapter V, Election of Officers, Section 1, be changed to delete the election of the First Vice President at the Annual Meeting, as the Second Vice President now automatically becomes the First Vice President after one year's term of office as Second Vice President. On motion duly made and seconded it was voted that Council refer this matter to the House of Delegates with the recommendation that this change be made in the Constitution and Bylaws.

(d) Chairman Alexander mentioned the fact that one or two county societies had about reached the 100 member mark and would be entitled to a councilor from that county society. These societies could be located in a district where there were already two councilors serving on the MAG Council. On motion (Bohler-Mauldin) it was voted that there not be more than two councilors from any one Congressional District; and further voted to refer this to the Constitution and Bylaws Board for study.

AMA Delegates Report

Dr. Chambers reported on the AMA meeting held in Los Angeles November 25-28, 1962. He mentioned the Southeastern States Hospitality Room plan, to be operated by an Executive Committee composed of one delegate from each southeastern state, and that the charge for maintaining the hospitality room would be appropriated according to the number of delegates from each state.

AMA Field Representative Report

Mr. Nelson made several brief remarks regarding the national legislative situation, MAG 1963 Projects, AMA-ERF, and a luncheon with the AMA delegates before the MAG quarterly Council meetings to discuss AMA matters.

Hospital-Medical Council Report

Dr. Cowart, Chairman of the Georgia Hospital-Medical Council, made a report of the Council's recent activities.

Report on October and November Meetings with State Board of Medical Examiners

President Goodwin stated that at the 1962 MAG House of Delegates, Council had been directed to establish a State Disciplinary Board. In order to follow up the action of the House, representatives of MAG and the State Medical Examining Board

had met on two occasions to discuss disciplinary actions. The State Medical Examining Board representatives stated they had the authority to act in the capacity of a disciplinary board. Dr. Goodwin then read the five point program suggested, as follows:

(1) "That in the interest of maintaining an understanding of each others organization's problems, it is recommended that the Board of Medical Examiners invite to attend certain meetings of the Board, a designated member of the Medical Association of Georgia. Similarly, the Medical Association of Georgia would so invite a designated member of the State Board of Medical Examiners to attend certain meetings of its Council, Executive Committee and Professional Conduct Committee. In this way, the two organizations working for a common purpose would maintain a proper and effective liaison on matters of disciplinary action affecting the practice of medicine in the state of Georgia.

(2) That in those cases of a physician's conduct requiring investigation the following procedure be instituted:

(a) that when the practitioner is a member of the Medical Association of Georgia, the County Medical Society having jurisdiction over this practitioner and the State Medical Association of Georgia should take full responsibility for initiating the investigation of that physician's conduct; take the proper action within the jurisdiction of the County Medical Society and the State Association concerning disciplinary action, and in those cases deemed serious enough to warrant consideration by the State Medical Examining Board, the Medical Association of Georgia would then turn over the complete file on such practitioner for disposition by the State Examining Board.

(b) that when the practitioner is not a member of the County Medical Society and the Medical Association of Georgia, the State Medical Examining Board should take full responsibility for initiating a complete investigation of the practitioner and would call on the Medical Association of Georgia to enlist the cooperation of the members of the County Medical Society and the State Medical Association in helping the State Medical Examining Board conduct such a full investigation.

(3) That a brief but comprehensive pamphlet on the subject of Medical Ethics in Georgia be co-authored and sponsored by a joint committee of the State Medical Examining Board and the Medical Association of Georgia and be jointly published by the two organizations for distribution to all physicians in the State of Georgia and medical students, etc. In discussing this recommendation, it was noted that such a project had been undertaken by the Medical Association of Georgia some years ago under the leadership of the then President of the Association, Dr. Hal Davison. It was suggested that this work be used as a start on such a project, if undertaken jointly by the two organizations.

(4) That consideration be given to a reapportioned appointment of the Board of Medical Examiners by the Governor of the State of Georgia on a district basis similar to the way the members of the State Board of Health are appointed. It was emphasized that this would take many years in completion so as not to involve any present members of the State Medical Examining Board. It was also brought out that if such a measure were given consideration, the Board would then better geographically represent the State of Georgia and the medical profession at large would feel closer to the membership of the Board in that it would be truly representative.

(5) That these suggestions be considered by the Board of Medical Examiners and the Council of the Medical Association of Georgia and after such consideration that the Liaison Committee as appointed originally meet again to consolidate and implement the suggestions made herein, if approved by both organizations."

This report and recommendations were approved as presented. This portion of the Council meeting was recessed at 5:30 p.m.

* * * * *

The Council meeting was reconvened at 8:20 A.M., December 9, 1962, by Chairman Alexander.

AMA Medicine-Religion Program

Dr. Paul McCleave, Director of the AMA Department of Medicine and Religion, described the pilot program of the Medicine and Religion Department and the selection of certain states for this program. Georgia is one of the states selected and a program will be held at the Sumter County Medical Society meeting, December 10, in Americus. The MAG Public

THE ASSOCIATION / Continued

Service Board is working with Dr. McCleave to encourage the county medical societies in this program.

REPORT ON HR 10—Dr. David R. Thomas and Mr. John Moore explained what is now known about H.R. 10 to Council members. Dr. Thomas discussed the actions of the Insurance and Economics Board and read the recommendations as follows: "Resolve that the Insurance and Economics Board recommends to Council that Poole and Wood Associates and the Citizens and Southern National Bank be asked to set up an Association retirement plan pursuant to H.R. 10 and that MAG retain the privilege to secure outside investment counseling as MAG may deem advisable. It was the feeling of the Board that should the need for outside investment counseling be advisable the firm of Montag and Caldwell be considered after consultation with Standard and Poor and other counsel. It was further the opinion of the Board that this action was merely a proposal and did not bind MAG to the services offered by either the C & S Bank or of Poole and Wood Associates." There was disagreement on the designation of specified firms at this stage of the investigation, and on motion (Goodwin-Mauldin) it was voted (1) to thank the Insurance and Economics Board for the work they have done; (2) to ask the Board to continue to work along this line; and (3) that their *investigation not be limited to any one source of advice or counsel at the present time* in working out this plan, and that the organizations mentioned in the recommendations listed above be so notified of this action.

County Medical Society Officers Conference and Public Service Board Activity

Dr. Bishop reported on the Public Service Board activities on practitioner identification, traffic safety, Weekly Health Column, and the County Medical Society Officers Conference program for March 2-3, 1963, was presented. Dr. Bishop asked the Councilors to attend the NCAA Coaches Clinic prior to the MAG County Medical Society Officers Conference if they could. On motion duly made and seconded it was voted that the Councilors should contact each County Medical Society President and Secretary in his district regarding attendance at the County Medical Society Officers Conference.

County Medical Society Membership Problems

(a) Southwest Georgia County Medical Society—Dr. Wilson stated there was a possibility of reactivation of the Randolph-Terrell County Medical Society. After discussion it was decided to delay the matter until the March Council meeting for a follow-up report at that time.

(b) Ware County Medical Society—Dr. Eldredge stated the request he investigated was one which required the member's membership in the Ware County Medical Society in order to have staff privileges at the Waycross Memorial Hospital. After discussion, on motion duly made and seconded it was voted to recommend that the matter be referred to the Waycross Memorial Hospital for action, with the thought in mind of changing their requirements for staff privileges to read "a physician is eligible for staff privileges if he is eligible for membership in the Ware County Medical Society or some comparable society."

(c) Coweta County Medical Society—Dr. Virgil Williams reported that he is in the process of investigating the inquiry from Coweta County Medical Society regarding membership in that society and will give a follow-up report at the March Council meeting.

MAG Board Appointments

Council was asked to approve the recommendations of the Executive Committee for appointment to the Legislative Board as follows: Thomas Gilmore, Sandersville (1963); William Harbin, Rome (1965); with an alternate, Lee H. Battle, Rome. On motion (Brown-Johnson) it was voted to approve the Executive Committee recommendations for appointment of the above to the Legislative Board.

Report on AMA Mental Health Congress

Mr. Krueger made the report for Dr. A. S. Yochem. There were many items recommended and on motion (Goodwin-Bohler) it was voted to refer this report to the Executive Committee for investigation and report back to Council at the March meeting.

Report on Blood Banks Sub-Committee

Mr. Krueger made the report for Dr. Jack Norris. On motion it was voted to receive the report for information.

Medicare Contract Renewal

Mr. Baker stated that the contract had been reviewed and was submitted for Council approval. Dr. Mauldin stated that Dr. Mercer's request that the fee which had been established for care of a newborn baby by a pediatrician be amended to state that the fee should be paid to any M.D. who takes care of the baby, would have to be decided before the contract was signed. On motion (McKemie-Williams) it was voted that Council supports Dr. Mercer's stand that the fee which has been established for care of a newborn baby should be paid to any M.D. who takes care of the baby; and that Council instructs the Executive Committee, in the renegotiation of the new contract, to seek to have the above changed; and if this is not accepted, the contract will be sent in as it is now written.

Headquarters Office Report

Mr. Krueger discussed the following:

- (a) Abner W. Calhoun Lectureship at 1963 Annual Session
- (b) MAG Annual Session Guest Speaker: Council submitted names for consideration. On motion (Goodwin-Mauldin) it was voted to ask those named in the order named.
- (c) AMA Medico-Legal Symposium, Miami, March 8-9, 1963: After discussion on motion it was voted to refer this matter to the Executive Committee with the power to act.

Old Business

Interprofessional Council Term of Office Expiration—Dr. William A. Wood's term of office on the Interprofessional Council is expiring. On motion it was voted to approve the Executive Committee's recommendation to reappoint Dr. Wood.

New Business

(a) Blue Shield of Columbus Resolution on Podiatrists was discussed and on motion it was voted that the Executive Committee should take this under advisement and report back to Council.

(b) Atwater Letter—Mr. Krueger read a "thank you" letter from Mrs. Atwater for flowers sent her recently.

(c) Goodwin Letter—Mr. Krueger read a letter from Dr. Goodwin thanking the Association for flowers sent him recently.

(d) AMA Disaster Care Meeting—Mr. Krueger read a letter regarding an AMA Disaster Medical Care meeting February 2-3, 1963, Biltmore Hotel, Atlanta. On motion it was voted to refer this letter to the Disaster Medical Care Sub-Committee with instructions to cooperate. Dr. Williams, Chairman of the Disaster Medical Care Sub-Committee, stated he would like to combine the meeting the MAG House of Delegates directed his Sub-Committee to hold and the AMA meeting mentioned above, and asked permission to do so. On motion duly made and seconded it was voted to allow Dr. Williams to combine these two meetings as carrying out the action of the MAG House of Delegates in this regard.

(e) Payment of Practical Nurse's Charge by Life of Georgia—An MAG member participant in the Life of Georgia Disability and Catastrophic Insurance Plan asked payment for a practical nurse when his wife was ill. At first this was denied by the company but after deliberation the claim was paid and the member was so notified. This was received for information.

(f) On motion duly made and seconded it was voted to express the appreciation of Council to Dr. and Mrs. McKemie, Dr. and Mrs. Brim, and Dr. and Mrs. Dillinger for their hospitality at this Council meeting.

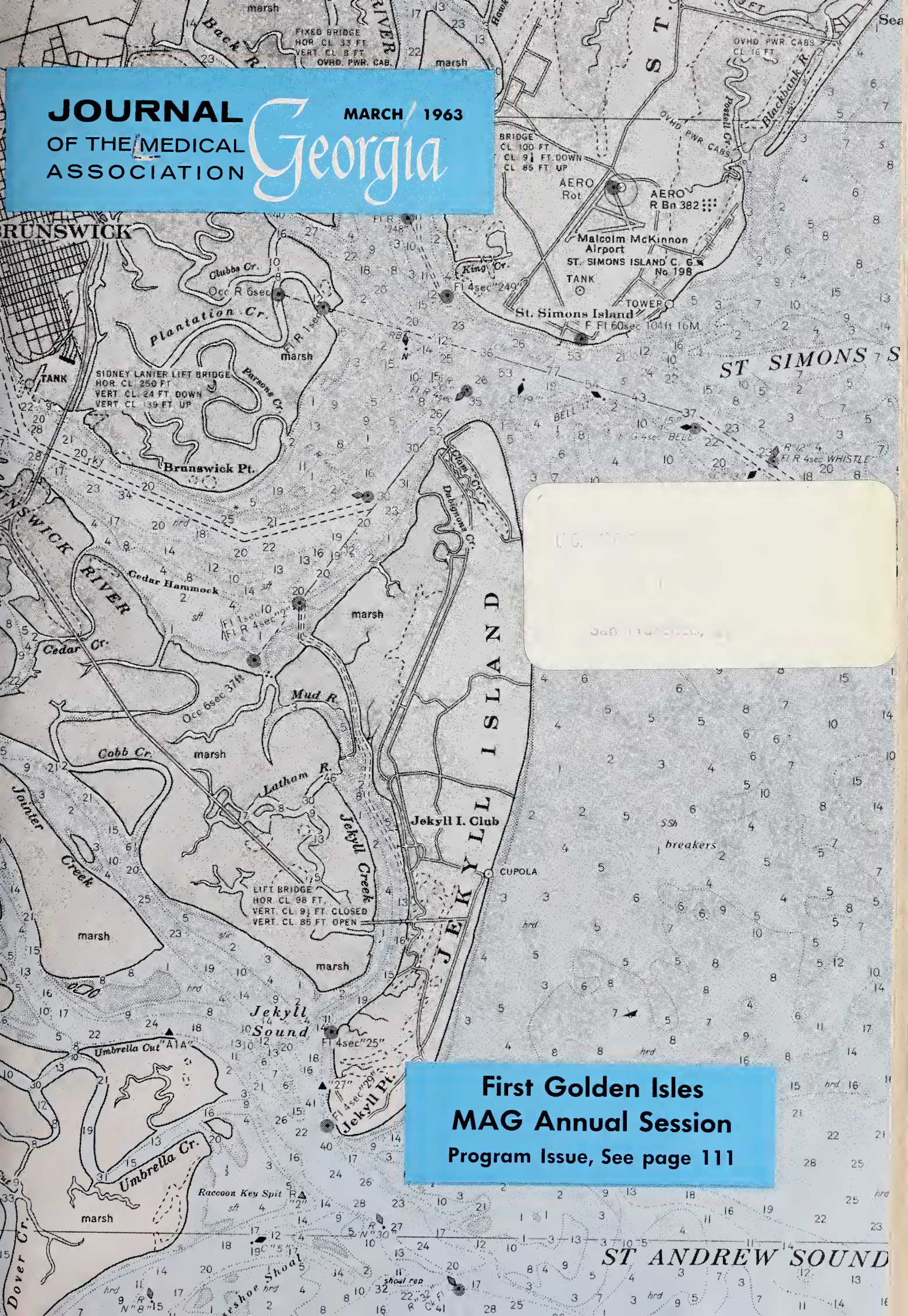
(g) Date and Site of March Council Meeting—Dr. Cowart and Dr. Chambers invited Council to meet at Callaway Gardens in March or June. Dr. M. A. Hubert extended an invitation to meet in Athens in March. Dr. Battle also invited Council to meet in Rome in March. On motion it was voted to accept Dr. Hubert's invitation to come to Athens on March 23-24, 1963. On further motion it was voted to accept the invitation to meet at Callaway Gardens with June 8-9, 1963, as tentative dates.

There being no further business the Council meeting was adjourned at 12:05 P.M.

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Georgia



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Contents

Scientific Articles

RECENT ADVANCES IN PEDIATRIC SURGERY Richard S. Owings, M.D.	97
THE USE OF PROMAZINE, MEPERIDINE, AND SCOPOLAMINE IN LABOR AND DELIVERY Carson B. Burgstiner, M.D.	101
OPEN REDUCTION OF ACETABULAR FRACTURES Waldo E. Floyd, Jr., M.D.	104
OCULAR TONOMETRY Morgan B. Raiford, M.D.	106

Editorials

AN ODE TO THE 109TH ANNUAL SESSION.	108
NEW ASPECTS OF THERAPY FOR SEVERE PANCREATITIS	109
COULD THIS BE YOURS?	110

1963 Annual Session Meetings

MAG OFFICIAL CALL, GUEST SPEAKERS, PROGRAM, AND OTHER DATA	111
WOMAN'S AUXILIARY, PROGRAM AND OTHER DATA	134

Features

How Well Are We Telling Our Story?	144
President's Letter	140
Cancer Page	141
Heart Page	143
Mental Health Page	145
Physician's Bookshelf	147
Current Clinical Concepts	149

The Association

Deaths	151
Societies	151
Personals	152
Executive Committee of Council Meeting, January 19	153
Advertising Index	52A

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The map on the March cover is from the U. S. Department of Commerce, Coast and Geodetic Survey, United States-East Coast, Georgia-Florida, Doboy Sound to Fernandina.

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RECENT ADVANCES IN PEDIATRIC SURGERY

Richard S. Owings, M.D., *Augusta*

■ **Five areas are discussed in which some of the more significant breakthroughs have occurred.**

BEFORE ATTEMPTING to touch on some of the recent advances in pediatric surgery, it might be worthwhile to define pediatric surgery. Pediatric surgery is surgery for patients in the pediatric age group, largely consisting of developmental surgical problems. Just as the medical problems of infants and children have been recognized as differing from the medical problems of adults — similarly, pediatric surgical problems and their treatment differ from the problems of general surgery. In the early thirties pediatrics divorced itself from internal medicine and set about and solved most of the problems in that field in a short period of time. It is surprising that pediatric surgery has been so slow in developing, since the common problems and certainly the developmental congenital problems have very little relationship to the surgery of adults. Nevertheless, pediatric surgery has come a long way towards solving many of the major problems in this field in a relatively short period of time. Dr. William E. Ladd was foremost in this country to demonstrate, by his example, the remarkable improvements in patient care that are possible by concentrating the efforts of an interested surgeon on pediatric age group problems. In almost every aspect of children's surgery to which he turned his attention, including tracheo-esophageal fistulas, congenital intestinal obstruction, common developmental urological problems as well as neoplasms — remarkably better results followed his efforts. A recent statistic that made the *Philadelphia News* headlines can perhaps best highlight this point — this is a public health figure which states that the death rate in the

United States for a laparotomy in the newborn period is 50 per cent — whereas the death rate for the same procedure in newborns in a well-organized children's center is less than five per cent.

Some 30 years ago Sir Lancelot Barrington Ward, senior surgeon for the Hospital for Sick Children in London, stated, "Adults may be safely treated as children but the converse can lead to disaster."

In reviewing some of the recent advances in pediatric surgery I will alternately discuss a common problem with a less common problem.

Hernias, Hydroceles and Undescended Testicles

What could be new about these common-place problems? The significance of a fluctuating hydrocele, which used to be treated primarily by reassuring the parents, is now generally recognized as associated with a communicating hernia above.

The presence of a short second toe or the apparent appearance of a short second toe with a deep cleft between the great and second toe in a consecutive series of 35 patients have all been associated with an indirect inguinal hernia. This is the first publication of this finding, and it should prove to be a highly accurate sign for inguinal hernia.

The significant microscopic finding of advancing testicular fibrosis after four years of age in the undescended testicle is a strong point for correcting this condition between one and four years of age, or certainly before school age.¹⁰ This finding has been repeatedly confirmed by testicular biopsies. There are a number of advantages to early correction. Early correction is technically easier; the fibrosis is limited so that the size of the testicle is

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more normal and the cellular content healthier. The psychological stigma of being unlike other boys, which is more significant as the child gets older, is circumvented.

Congenital Hypertrophic Pyloric Stenosis

Pyloric stenosis is probably the most common abdominal surgical problem of infancy. Fifty years ago an infant with this condition faced an over-all mortality of 50 per cent.¹¹ Today, in most institutions the outlook for an infant with this condition is extremely bright in about 99 per cent of such cases. There is much speculation as to the possible etiology. Over-activity of the autonomic nervous system with resulting pylorospasm has been postulated as a precursor of pyloric stenosis, but there is little clinical evidence to support this contention. If that concept were valid, one might well expect an increased incidence of peptic ulceration in such individuals but this is not the case. A long term follow-up study by Ferguson and Jewett⁵ on a group of 56 patients operated at the Children's Hospital, Boston, failed to disclose an increased incidence of ulcer diathesis. This study perhaps can be criticized somewhat in that the patients ranged from 24 to 32 years of age. Of the 56 patients there was only one with a definite peptic ulcer and two additional patients who had symptoms suggestive of ulcer. The incidence of three in 56 compares favorably with previously reported figures of peptic ulcer in the population at large,⁵ but probably not for such a young age period. There may be some slight increase in the incidence of allergy in the background of patients with pyloric stenosis. In this particular series of 435 patients during a one year period of evaluation which roughly represents 75 patients, 15 had a history background of major allergy (asthma or eczema). An additional finding in this one year period was that in eight patients there was one or more grandparent with diabetes, but no parents. Since diabetes tends to skip generations, this lead should be followed up and some determination made as to the subsequent incidence of diabetes in pyloric stenosis patients. The over-all mortality at the Boston Children's Hospital from 1953-59 in 435 patients was 0.69 per cent. Two of the three deaths were preventable — one due to an overwhelming staph pneumonia with septicemia — the other occurred in a depleted infant who vomited four days post-operatively and aspirated.¹⁰

Wilm's Tumor and Neuroblastoma

Many factors should be considered when evaluating the effectiveness of the treatment of Wilm's

tumor. The age of the patient, promptness of diagnosis and the concomitant presence of signs and symptoms may be almost as important as the specific type of therapy. In addition, the late complications which result from certain types of therapy warrant attention. For instance, there is no evidence that the survival rate is increased for patients treated in the first 12 months of age by the addition of irradiation following surgical excision.¹⁴ From the reports available, it appears that infants up to 12 months treated by surgery alone have just as good a survival rate if not better than those treated by X-ray alone.^{13, 14}

Tenacity Worthwhile

Tenacity in treatment is very worthwhile in a large percentage of the apparently hopeless cases of both Wilm's tumor and neuroblastoma. I have accumulated 15 patients with Wilm's tumor who have had secondary pulmonary metastatic lesions which were treated with 1200 R. to the thorax and which have subsequently proven to be "cures." *Personal communication* The fallacy of irradiation to the renal fossa is perhaps highlighted by the autopsy findings of 56 patients reported by Johnson⁹ in which he notes the rarity of local recurrences in the renal fossa even when the lungs were widely studded with tumor. Therefore we may conclude that for patients under one year of age whose tumor has been removed cleanly — irradiation is not indicated — particularly in view of the fact that as little as 600 R. will permanently affect an epiphysis.

Symptoms Estimate Survival

The presence of other symptoms also plays an important role in estimating survival. One symptom such as hematuria has little influence on survival but the presence of two or more symptoms greatly decreases the survival outlook.¹³ Symptoms include the mass, fever, hematuria, elevated blood pressure, etc. In a comparison of 18 patients with careful follow-up studies from Strong Memorial Hospital in Rochester, the presence of two or more symptoms was associated with a spiralling increase in mortality. In this report there were ten "cures" all of whom had received irradiation. Four of these children had significant late bony changes — gibus and/or scoliosis.^{11, 13}

Collin's Rule

Collin's rule as a method of estimating prognosis in Wilm's tumor is a useful contribution.^{3, 4} Collins has made serial observations on the growth rate of pulmonary nodules of Wilm's tumor. From these observations he has estimated and correlated a quantitative rate of growth suggesting a uniform growth rate. On this basis he uses the simplest con-

cept for the multiplication of cancer cells — he begins with a single cell which initiates a series of doublings (2-4-8 etc.) to establish a colony of tumor cells. From this he calculated that a single cell ten micrometers in size would require 20 doublings to be equal to one mm. in diameter. Another ten doublings would be required to equal one cm. (still at the same rate of growth) at which time the tumor would be one kilogram in weight. Since no tumor can be older than the patient's age plus nine months (gestation period) a sliding scale period of risk can be devised so that if the tumor is not clinically evident again within a similar period of time — namely a period equaling the patient's age at the time of diagnosis and treatment plus nine months — then he may be considered a "cure." For example, a patient first diagnosed and treated at four months of age would be closely followed for a minimum of 13 months following surgery — if no clinical recurrence of the tumor became manifest during this period, the child would be considered a "cure." This method of estimating prognosis has withstood critical evaluation involving over 200 patients of Collins, 18 of my own, as well as a series of 200 cases from the Boston Children's. In no case did a patient die from his tumor or did the tumor again become clinically evident beyond this predicted period of risk.

Improved Cure Rate

As with Wilm's tumor, the cure rate of neuroblastoma has steadily improved. Much of this is due to the adjunct of chemotherapy to surgery and X-ray. The over-all cure rate for children under 12 months of age is in the range of 90 per cent. Even with hepatic metastasis, the cure rate is 65 per cent. The only real hopeless omen is in patients with X-ray evidence of bony metastasis.

There are certain interesting associations with this tumor. One is the long-known association of hypertension and, more recently, there have been reports of carcinoid-like symptoms including asthma, abdominal distention, and diarrhea. A substance identified as vinyl mendelic acid (V.M.A.) which is a breakdown product of the catechol amines has been found to be present in large quantities in the urine of patients with such symptoms. Unlike in malignant carcinoid, this does not depend on hepatic metastasis for its appearance. The substance disappears after complete excision of the tumor, and carcinoid symptoms likewise subside. Another interesting observation which is as yet unpublished is the collaborative report from a number of experienced pediatric surgeons who have yet to see a death from neuroblastoma confined to the mediastinum or chest, when the tumor is completely removed. Cure rate under such circumstances, even when highly malignant, is con-

siderably better than when the tumor is present in the abdomen. The multi-centric origin of this tumor anywhere along the paraspinal nerve trunks is also of interest in that separate primaries may be found and they should be treated not as metastatic areas but as separate tumors.

Exstrophy of the Bladder and Cloaca Problems

Exstrophy of the bladder has long been a controversial and difficult therapeutic problem. Several key anatomical observations have led to improvement in results including a higher percentage of urinary continence. Dr. Tague C. Chisholm of Minneapolis^{12, 17, 18, 19} has emphasized certain points which have led to better long-term results. Anatomical studies indicate that the sphincter is a splayed out ribbon which lies posterior to the exposed mucosa of the urethra and connects the diasthesis of the symphysis pubis. The nerve supply to the sphincter comes in right at the subperiosteal area. Former methods of repair were no doubt associated with severance of these nerve bundles. Also it is important to remember that if the bladder can be turned in early, this larger bladder has less shrinkage and less redundant mucosa. Cracking the ilial wings bilaterally and rotating the symphysis pubis medially to re-connect these bones allows for three important results: (1) no dissection about the sphincter or its nerve supply is necessary (2) the sphincter can be re-approximated (3) the very important 90 degree angle between the bladder and the urethra can be developed. Dr. Chisholm reports on his experiences with 35 exstrophy patients and states that his results have steadily improved. Of his last 12 patients all six of the females have good control, two of the boys have excellent control, two still dribble but are less than three years of age. One has a fistula at the vesico-urethral junction and one has a dehiscence. It is certainly encouraging that such good results are being obtained with this very difficult problem.

Pathological Anatomy

In regard to cloaca problems, again the recognition of the pathological anatomy holds the key to success. In this problem, in addition to the associated imperforate anus, there is generally a bifid bladder separated by a strip of intestine which is the ileal-cecal valve region. It is tremendously important *not* to remove the unused tiny colon (once called micro-colon).¹⁵ The first step in correction should be to free any associated omphalocele and the bifid bladders and then approximate the bladders in the midline, thereby creating an exstrophy. The ileal-cecal region should then be brought out as a

cecostomy-colostomy and the micro-colon, if possible, brought through as a pull-through. That this lesson was hard to learn is evidenced by the fact that of the 17 patients reported by Dr. Gross, only two have survived. Despite the apparent catastrophic combination of problems which these patients present, it is certainly my feeling that every effort should be made to correct these anomalies aggressively. This is a very rewarding effort now that we have a better understanding of the problem in that these children have normal motor function and mentality and, although their problems are great, they are largely confined to a local field. When we think of the efforts made in such fields as cerebral palsy to aid in partial self-help of children who can never be self-sufficient citizens, how evident it is that at least equal effort should be focused on cloaca patients who have the potential for 90 per cent normality in all of their functions.

Omphalocele

There are three significant contributions in the treatment of omphalocele. One is the very important sequence of correction — the liver should be placed back in the abdomen first so that the diaphragm and costal margin can develop. Later, if only skin can be brought across the remainder of abdominal content, a plastic bag may be sutured to the fibrous ring and later tightened at ten day intervals to allow the underdeveloped abdominal cavity to gradually adapt itself to admit the remainder of the abdominal organs.⁷ By this progressive approach, very large omphaloceles are now within the realm of correction.¹⁶

Grob has achieved remarkable results in certain omphaloceles using two per cent mercurochrome to form an eschar. This gradually dries, shrinks and contracts the amnion covering of the omphalocele. Because of the prolonged nursing care necessarily associated with Grob's method perhaps this method of care should be confined to omphaloceles occurring in prematures.¹⁶

In closing, there have been great advances in almost every sphere of pediatric surgery. I have attempted to single out only a few of the most significant breakthroughs in diagnosis and treatment.

1467 Harper Street

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EVIDENCE OF DRUG EFFECTIVENESS SITED

To be truly effective, the medical profession needs an expanded and improved arsenal of drugs. We have confidence that the American prescription drug industry, if permitted to operate in an atmosphere of freedom, can supply that need. In our judgment, both the industry and the medical profession—and ultimately the American people—would suffer if Government were to require anything more than substantial evidence that a drug is effective for the use claimed for it. By "sub-

stantial" evidence we mean that the clinical testing data submitted to the Food and Drug Administration should be performed by truly competent and qualified clinical investigators and that the medical evidence supporting the claim of effectiveness should be significant.—I. S. Ravdin, M.D., Professor of Surgery, University of Pennsylvania School of Medicine, to House Interstate and Foreign Commerce Committee, August 20, 1962.

THE USE OF PROMAZINE, MEPERIDINE, AND SCOPOLAMINE IN LABOR AND DELIVERY

Carson B. Burgstiner, M.D., *Savannah*

■ *Balanced analgesia produces a desirable set of circumstances in this clinical situation.*

THE PURPOSE OF THIS PAPER is to present our cumulative experience with a balanced type of analgesia which has proven satisfactory for mother and baby in labor and delivery. "Balanced Analgesia" utilizes smaller doses of several agents which function by different mechanisms, each potentiating the pharmacologic activities of the others, producing more pronounced therapeutic effects with fewer side reactions.¹⁰

It has been shown that the employment of a tranquilizer, in addition to meperidine, as contrasted with meperidine alone, decreases the patient's pain or anxiety responses to labor significantly.⁶

Requirements Must Be Met

Drugs used during labor and delivery must meet certain requirements: They must: (1) be effective in relieving pain (2) be safe for the mother and infant (3) not interfere with the normal mechanism of labor.¹¹ The ataraxic drugs appear to lessen the potentially harmful effects of standard analgesic-amnesic drugs by potentiating them, thus reducing the required dosage. The drugs further tranquilize the apprehensive patient in addition to a pronounced antiemetic effect.¹¹ In our community, because of a lack of obstetric anesthesiologists, it became necessary to develop a satisfactory substitute for the usual anesthetics used in labor and delivery. The combi-

nation of Promazine (Sparine®), Meperidine (Demerol®), and Scopolamine fulfilled the need and is now used by all of the obstetricians and many of the general practitioners in labor and delivery in the Savannah area. The key to the efficiency of our balanced analgesia appears to be Promazine. We have used other phenothiazines with the widely used combination of Meperidine and Scopolamine and have been unable to duplicate the results. This combination has been used almost exclusively on our obstetric service since 1957.

Value of Promazine

Stewart,¹² in evaluating four different phenothiazines in labor and delivery, concluded that Promazine affected the better analgesia and obtained more amnesia than the other drugs. Stewart adds that patients who are carried through labor in a state of relaxation uncomplicated by fear and tension usually have easy, uncomplicated deliveries with rapid cervical dilatation and descent of the presenting part. This, he feels, is due to a near perfect neurohormonal balance. Experimentally, it has been shown that epinephrine can block the action of oxytocin at its source and site of action; therefore, the tense, fearful patient with excessive elaboration of epinephrine results in oxytocic inactivation and prolonged labor. The phenothiazine drugs appear to reduce this epinephrine influence and permit a normal oxytocin-epinephrine ratio and a normal progressive labor ensues.

Presented at the 108th Annual Session of the Medical Association of Georgia, May 6, 1962, Savannah, Georgia.

Material and Method

Our series comprised 1,000 women, ranging from 12 to 48 years of age, who had been admitted to the obstetric service of Memorial Hospital of Chatham County. This study represents 1,000 consecutive deliveries (excluding Caesarean sections), beginning January 1, 1960. 329 (32.9%) were primiparas and 671 (67.1%) were multiparas. These cases were evaluated and discussed with respect to (1) dosage of drugs used during labor and delivery (2) effect on age or parity (3) type of labor and average duration (4) maternal pulse, blood pressure, respirations and fetal heart tones during labor and delivery (5) methods of delivery (6) degree and duration of pain relief and amnesia (7) effects of analgesia on fetus with APGAR #.

Decision for Dilution

Promazine, Meperidine, and Scopolamine were mixed together in the same syringe and diluted to ten cc. with sodium chloride, USP. The decision to dilute the mixture arose because of reported cases in the literature of slough at the site of administration when given other than intravenously.⁸ There have also been reports of allergic reactions to personnel who were administering the medication. We have had minimal untoward reactions since dilution was begun. There have been several cases of superficial nodulation with inflammation and induration of vessel walls without subsequent sequelae. The dosage was individualized according to the progress of labor, needs, and mental status of the patient. The initial dosage was usually given at 4.0 cm. in the primigravidae with regular contractions and 3.0 cm. in the multigravidae in labor. Some patients who were exceptionally apprehensive, received barbiturates (100-200 mgm) orally or intravenously in a single dose, prior to onset of true labor. Some of the local physicians feel that the unusual relaxation accorded the patient lessens the possibility of uterine rupture during intravenous oxytocin induction. It appears that administration of this medication just prior to delivery has not resulted in untoward depression of the infant.

Drug Dosages

DRUGS:	(Initial Mgm) AVERAGE DOSE	TOTAL DOSE FOR LABOR AND DELIVERY (Mgm)	
		Range	Average
Promazine	(25-50)	12.5-100	42.5
Meperidine	(25-50)	12.5-200	60.0
Scopolamine	(.4-.6)	.3-1.5	0.6

My own dosage schedule, after observing the vari-

ous combinations used during the past three years, as as follows: (in the average size patient)

Demerol	50 Mgm
Sparine	50 Mgm — IV
Scopolamine	0.6 Mgm

If necessary to repeat in three or four hours:

Demerol	25 Mgm
Sparine	25 Mgm — IV
Scopolamine	0.4 Mgm

If necessary to repeat in three or four hours:

Demerol	12.5 Mgm
Sparine	12.5 Mgm — IV
Scopolamine	0.2 Mgm

There does not appear to be a significant difference in the effect of this medication on age or parity as far as tolerance is concerned. It does appear, however, that less medication is required for elderly multiparas whereas the opposite is true of the young primigravida. The duration of labor was shortened in primipara and multipara.

Labor (Type and Average Duration)

TYPE			
Spontaneous			502 patients
Induced (IV pitocin with artificial rupture of membranes)			66 patients
Artificial rupture of membranes only			432 patients
AVERAGE DURATION*			
Primiparas	329 patients	9 hrs. 55 minutes	
Multiparas	671 patients	4 hrs. 32 minutes	
TOTAL	1000 patients	6 hrs. 06 minutes	

SOME COMPARISONS OF AVERAGE DURATION OF LABOR:

Analgesic Medication: Primiparas No. pts. Multiparas No. pts.			
Eastman ⁹	14.0 hrs.	8.0 hrs.	
Delee and Greenhill ⁴	14.45 hrs.	12.5 hrs.	
Busby ³	13.0 hrs. <u>4243</u>	8.15 hrs. <u>4227</u>	

The vital signs were recorded on admission, at intervals throughout labor, and immediately after delivery. The fetal heart tones were determined in accordance with standard practice during periods between contractions. Blood pressure values did not differ more than ± 15 mm. Hg. systolic and diastolic. Pulse rate was accelerated in all instances to 100-110/min, usually returning to a normal rate within 5-15 minutes after injection. Fetal heart tones seemed unaffected. Maternal respiratory rate also remained unaffected. This medication was not given to patients for elective Caesarean sections, however, in those cases where emergency Caesarean section was necessary, the tendency toward hypotension when used in conjunction with inhalation and regional anesthesia was easily overcome in all instances using vasopressors (vasoxyl, neosynephrine). Despite the fact

* Induction cases were included in this group, thus probably further shortening the average duration of labor.

that general anesthesia was not used, except with Caesarean sections, all the usual types of delivery, including version and extraction of second twins, were performed without causing the patient discomfort and without the need of additional medication. Manual removal of the placenta was also carried out without additional medication.

METHODS OF DELIVERY

Primigravidae 329 Pts. 32.9% — Multipara 671 Pts. 67.1%	
Spontaneous	753
Forceps	214
Asst'd Breech Extraction	28
Version and Extractions (twins)	5
TOTAL	1000

Deliveries with or without episiotomy and forceps were frequently done with sedation only. Anesthesia was usually unnecessary; however, local infiltration or pudendal block was occasionally necessary.

Amnesia seemed to be complete in 83 per cent of the women and partial in the other 17 per cent, in those patients receiving recommended doses of scopolamine.*

As observed by Pollock,¹⁰ et al, most patients recalled nothing from the time the first dose of medication was administered until they awakened on the postpartum floor. The effects usually lasted six-eight hours postpartum. Patients slept soundly for two-four hours, and more lightly thereafter. Patients were usually surprised on awakening to discover that they had delivered. Patients were usually completely relaxed and quiet. They reacted to external stimuli and usually showed some movement during contractions, with deep sleep between contractions. Most patients had an attitude of indifference to their condition and their environment. It is usually necessary to observe these patients closely to avoid spontaneous delivery in bed.

Promazine appeared to lower the incidence of nausea and vomiting to a degree similar to that reported for other phenothiazines (prochlorperazine) by Kappelman,⁷ and (perphenazine) by Phillips,⁹ et al. They reported that vomiting occurred in 11.8 per cent of patients receiving meperidine and a placebo. Only 45 women, 4.5 per cent, in our series vomited during labor and delivery.

The condition of the infants one minute after delivery was evaluated by the method of APGAR¹ as follows:

Score	No. Infants	Per Cent
0-4	38	3.8
5-7	192	19.2
8-10	770	77.0

* 100 consecutive patients.

The average APGAR score was 7.68, indicating a high degree of safety in the conduct of labor and delivery.

Summary

The effects of a balanced type of analgesia, consisting of Promazine, Meperidine, and Scopolamine were observed during labor and delivery on the obstetric service of Memorial Hospital of Chatham County. The ataraxic effect of Promazine resulted in fewer doses of narcotics and barbiturates. No reduction of uterine contractions was noted (except when medication was given prior to 3.0 cm. dilatation and regular contractions). No significant circulatory or respiratory depression was noted.

APGAR Score

The average APGAR score for infants was 7.68, indicating a wide margin of safety to infant, as well as mother. Labor in primigravidae and multipara was noticeably reduced in duration. All types of delivery were performed without additional medication. The incidence of nausea and vomiting was very low.

Conclusions

Intravenous injection in recommended dosages of a balanced analgesia using Promazine, Meperidine, and Scopolamine results in satisfactory relaxant, amnesic, analgesic and antimetic effects and accords the mother and infant a wide margin of safety in labor and delivery.

12 Clark Terrace

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OPEN REDUCTION OF ACETABULAR FRACTURES

Waldo E. Floyd, Jr., M.D., *Macon*

■ *Many fractures can be treated advantageously by this method.*

IN recent years the attitude of defeatism by Orthopedic Surgeons toward central fractures of the acetabulum has changed to one of aggressiveness. The standard principals of treating fractures apply to acetabular fractures as well as any other. The more anatomical the reduction, the earlier will be the return of function and less will be the chances of degenerative changes and disability. Operative reduction of acetabular fractures has been discouraged in the past because the exposure and the reduction were felt to be too difficult. It was thought that despite the poor X-ray results, following simple conservative treatment, the functional result was good. However, this is misleading because after a year or two, arthritic changes set up and nearly always a painful hip develops. Fusion or arthroplasty often has to be performed in order to relieve this condition.

Levine was the first in 1943 to describe his experience with open reduction of one patient's acetabular fracture. Urist in 1949 reported another. Okelberry in 1955 reported his experience with seven patients. He used an anterior iliofemoral approach in all. Elliott in 1956 reported three patients. In 1959 Knight and Smith, at the Campbell Clinic, reported their results in the management of acetabular fractures by open reduction. Their results were far superior to any other series.

Varying Treatment

Central dislocations of the hip have been treated by lateral sling traction, Bucks extension traction, Woods screw traction through the greater trochanter,

Steinman pin traction through the distal femur, and proximal tibia. They have been treated in and out of spica cast and by Anderson well leg traction. As is the case in nearly all of these techniques, it is difficult to maintain traction and at the same time keep the patient free of decubitus ulcers. Certain type casts with continuous traction have been devised to prevent this complication. However, none of these procedures is quite so good as open reduction and internal fixation. The acetabulum is practically the inside of a sphere. It has a defect in its inferior portion near where the ligamentum teres attaches. The weight bearing vault is in the superior aspect of the acetabulum. The acetabulum may be divided into four quadrants and for matters of reference can be illustrated like the face of a clock. Viewing the left acetabulum, the most superior point is 12:00. The inferior defect is at 6:00. The posterior mid-point is 3:00. The anterior mid-point is 9:00.

Critical Portion

The most critical portion of the acetabulum is the weight bearing vault from 10:00 to 3:00. Fractures through this portion should be reduced anatomically in order to prevent degenerative and arthritic changes. The great majority of fractures through the acetabulum may be divided into vertical and horizontal type fractures. Which one is produced is dependent upon the forces causing the injury. In the vertical type fracture, this fracture line runs in a direction from near 12:00 to around 6:00. On X-ray examination of this type fracture a double vault of the weight bearing portion of the acetabulum is seen. In the horizontal fracture, the fracture runs

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roughly from 9:00 to 3:00. The fracture seems to extend into the pelvic rim along the pectoneal line. It may be necessary to use stereoscopic views in order to determine which type fracture is encountered; however, this usually is not necessary. Knight and Smith determined that it was best to explore the vertical type fractures through a posterior approach, using the technique of Henry, and that it was best to explore the horizontal type through an anterior iliofemoral Smith-Peterson approach. These respective approaches give better exposure and ease of reduction for the particular type fracture.

Twenty-six Methods

We have performed open reductions of the acetabulum in 26 cases. Five of these were for posterior lip fractures. Six were for vertical fractures of the acetabulum and 14 were for horizontal fractures of the acetabulum. Vertical fractures are usually easy to reduce, but the exposure is more difficult. These fractures may be reduced by inserting two Steinman pins on either side of the fractures and then using a Lane bone holding forcep to approximate the Steinman pins thereby reducing the fracture. The horizontal fractures are best reduced by using a Bishop ice tong bone holding clamp. This is a large enough clamp that both fragments may be grasped and pulled together. Because of the great forces involved and the weight of the leg, even this is difficult if manipulation is not carried out at the same time. We have found that in these horizontal fractures it is best to reduce them by what we call 90-90 traction by markedly flexing the hip and the knee and pulling the knee in a vertical fashion. Usually two large wood or lag screws are used to maintain the reduced fracture. Weight bearing is denied until X-rays demonstrate healing of the fracture, which is usually complete in ten to 12 weeks.

We had one patient walk on a horizontal fracture in two weeks. The fracture healed well and the patient has had no difficulty. We had one patient, who was pregnant, who had had an open reduction some ten years previously who was maintained with Steinman pins. She had a good functioning hip and the fracture was completely healed. At the time of delivery stereoscopic views revealed that one of the pins had migrated and it was impossible to deliver the head without removing the pin; therefore, an

intrapelvic incision was made and the pin was removed. The patient delivered without complication. Our follow-up ranges from ten years to six months. We have had no evidence of arthritis and no serious complications. All the fractures healed without delay. One patient had a markedly comminuted fracture of the middle third of the femur and horizontal fracture of the acetabulum. The acetabulum was treated by open reduction with two large wood screws and the femur placed in traction. Both fractures healed well and the patient was up walking in a brace in three months.

The advantages of open reduction of the acetabulum are, better anatomical reduction, fewer incidents of osteoarthritis, fewer incidents of bed sores, early ambulation and no need for skeletal traction or spica cast. To a certain extent our cases have been selective. There are some acetabular fractures that, because of their marked comminution and because of complications such as compound wounds and associated fractures of the head and neck of the femur, do not lend themselves well to open reduction and internal fixation. However, most acetabular fractures can be treated in this manner and when they can, the results are far superior to the old technique of traction, external immobilization and temporization.

801 Spring Street

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MEDICAL SEMINAR TO BE HELD IN ALBANY

The Eighth Annual Albany-Southwest Georgia Medical Seminar will be held April 25, 1963, in the Grand Ballroom of the new Albany Hotel. A series of lectures, demonstrations, and round tables will be presented by

the faculty of Bowman Gray School of Medicine, Winston-Salem, N. C., for the physicians of Southwest Georgia, North Florida, and South Alabama, under the sponsorship of the Dougherty County Medical Society, Albany.

OCULAR TONOMETRY

Morgan B. Raiford, M.D., *Atlanta*

■ **No physical examination is complete without evaluation of the ocular tension by Tonometry.**

NO PHYSICAL examination is complete without the evaluation of the ocular tension by Tonometry. This valuable and informative test should not be the sole propriety of ophthalmology. Glaucoma is one of the greatest causes of blindness. We of medicine are at least physiological referees and must use at all times the valuable informative data that is afforded us by history and physical findings to seek out the etiologies of the abnormalities that afflict one's being.

1. To the ophthalmologist, Tonometry is always a part of the ocular examination.
2. To the patient who reads of the blinding fear of glaucoma, it is of considerable assurance that the ocular tension is within normal range.
3. To the diagnostician, whether it be in general practice, surgery, industrial or internal medicine, the Tonometer should always be used as part of the examination.
4. By detecting early elevation of ocular tension, the silent destructive forces of glaucoma that steal our vision can creep upon both the patient and the examining physician to an alarming degree.

The writer has seen a glaucoma patient treated for gastrointestinal disorders, having had his gall bladder removed in one of the great metropolitan medical centers, from the reflex stimulation due to glaucoma in each eye through cranial nerves affecting the vagus complex. This patient is now totally blind because of failure to recognize the elevated ocular tension which produced this chain of nerve stimuli. The ocular tension was not measured as part of the initial physical examination.

Likewise, a reverse in this physiology can bring about a false glaucoma. Endocrine imbalance—the menopausal syndrome through its parasympathetic-metabolic relationships. By history, examination, and Tonometry, these patients can be prevented from having unnecessary glaucoma surgery.

Tonometry is a reliable clinical guide that should be easily accessible to all physicians. The Shiotz Tonometer has proven through the years as a most reliable and sturdy instrument. Others have been designed, mechanical and electronical, though they have not demonstrated any superior qualities for the measurement of ocular tension in clinical examinations. Proper care, sterilization (ether, alcohol, heat, ultraviolet) should always be used to avoid cross infection. A topical anesthetic drop in each eye and an explanation to the patient to facilitate the lid relaxation, should be done by the physician. Having a point of fixation on the ceiling of the examination room is a useful aid (a metal house number 3-4 inches high is quite adequate) to enable the patient to fix with opposite eye and steady the corneal position makes the Tonometry test easier and more accurate. A pipe stem cleaner is useful in preventing the mucus portion of adherent tears from collecting in the shaft of the tonometer.

Physical Examination

A good standardized certified Tonometer can be kept accessible for each and every complete physical examination. The pre-employment examination in industrial medicine should always render an ocular Tonometric test. In geriatrics, the sclerotic changes of the anterior segment of the eye and the senile lens swelling, which the elderly patient terms "second sight," may be an optical benefit but carries with it chances of glaucoma. The ocular Tonometry test can be of untold value to our senior patients.

The eye is the most complex of our body senses. We need all the help possible to maintain our visual ability. As from Shakespeare, "The eye is a mirror of our soul." In medicine the eye is a, "mirror of our physiology." No physical examination is complete without the testing for ocular tension—the use of the Tonometer is for every physician.

*Ponce de Leon Infirmary
679 Juniper Street, N.E.*

A motion picture film, CLINICAL TONOMETRY, B&W, 16 mm sound—six minutes running time is available on short term basis (one week) free of charge. Communicable Disease Center. Attn: National Audio Visual Facility, Atlanta 22, Georgia.

1963 CALENDAR OF MEETINGS

State

March 27-29—Postgraduate Course, "Three Days of Cardiology," sponsored by the Council of Clinical Cardiology, American Heart Association, and the Department of Medicine of Emory University School of Medicine, Grady Memorial Hospital Auditorium, Atlanta.

March 28-30—Annual Meeting of the Georgia Society of Ophthalmology and Otolaryngology, General Oglethorpe Hotel, Wilmington Island, Savannah.

April 5-6—Third Georgia Conference on Handicapped Children, "Genetics and Handicaps," sponsored by the Nemours Foundation, DeSoto Hotel, Savannah.

April 14 - June 9—Seminars on the fundamental mechanisms of disease, sponsored by the Independent Non-Profit Hospitals of Atlanta: April 14—"The Approach to the Pulmonary Problem"; May 12—"Basic Hormone Effects on the Female;" June 9—"Virology: Its Background in Current Clinical Concepts."

April 25—Eighth Annual Albany-Southwest Georgia Medical Seminar, Grand Ballroom, Albany Hotel, Albany.

May 5-8—109 Annual Session of the Medical Association of Georgia, Aquarama, Jekyll Island, Georgia.

Regional

October 1962 - November 1963—Fourteen Postgraduate Courses offered by the University of Tennessee College of Medicine: March 21-23—"Surgery of the Hand;" May 15-17—"Emotional Disturbances of the Adolescent;" May 22-24—"Fractures and Dislocations."

March 22-27—North American Clinical Dermatologic Society, Diplomat, Hollywood, Fla.

March 24-28—International Anesthesia Research Society, The Americana, Bal Harbour, Miami Beach, Fla.

March 29-31—American Otorhinologic Society for Plastic Surgery, Fountainebleau Motor Hotel, New Orleans, La.

April 1-5—Thirty-sixth Annual Spring Congress in Ophthalmology and Otolaryngology sponsored by the Gill Memorial Eye, Ear, Nose and Throat Hospital, Roanoke, Va.

April 7-10—Tennessee State Medical Association, Andrew Johnson Hotel, Knoxville, Tenn.

April 16-19—American Dermatological Association, The Homestead, Hot Springs, Va.

April 17-20—Sixteenth Annual Meeting of the West Virginia Academy of Ophthalmology and Otolaryngology, Greenbrier Hotel, White Sulphur Springs, West Va.

April 21-22—American Laryngological Association, Hollywood Beach Hotel, Hollywood, Fla.

April 23-25—American Laryngological, Rhinological and Otological Society, Hollywood Beach Hotel, Hollywood, Fla.

April 25—American Society for Head and Neck Surgery, Hollywood Beach Hotel, Hollywood Beach, Fla.

May 13-15—American Gynecological Society, Roosevelt Hotel, New Orleans, La.

May 27-29—American Ophthalmological Society, The Homestead, Hot Springs, Va.

National

March 18-30—Department of Otolaryngology, University of Illinois College of Medicine, Postgraduate Course in Laryngology and Bronchoesophagology, Chicago, Ill.

March 24-29—American College of Allergists Graduate Instructional Course and Nineteenth Annual Congress, Americana Hotel, New York City.

March 29-31—American Society of Internal Medicine, Brown Palace Hotel, Denver, Colo.

March 29 - April 5—American Academy of General Practice, Chicago, Ill.

April 1-5—American College of Physicians, Denver Hilton Hotel, Denver, Colo.

April 4-6—Eastern Conference of Radiology, Bellevue-Stratford Hotel, Philadelphia, Pa.

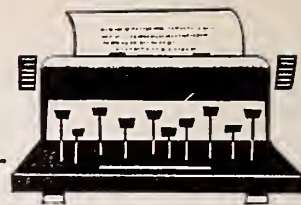
April 8-10—American Association for Thoracic Surgery, Shamrock Hilton Hotel, Houston, Tex.

April 21-24—American College of Obstetricians and Gynecologists, Statler Hilton Hotel, New York City.

May 27-31—Five Day Refresher Course in Pediatrics for Pediatricians and General Practitioners, The Children's Hospital of Philadelphia, Philadelphia, Pa.

June 13-17—Twenty-ninth Annual Meeting of the American College of Chest Physicians, Atlantic City, N. J.

June 16-20—American Medical Association Annual Meeting, Atlantic City, N. J.



An Ode to the 109th Session

(Welcome to Jekyll)

MEDICINE MEN, leave lowlands and highlands,
Go get your wives and come down to the islands.
MAG is in session in May,
From 5th through 8th, so do plan to stay.

There'll be meetings, of course, to inform and enlighten,
Well-qualified speakers — you've all read their writin'.
Specialty meetings — anesthesia, urology,
Surgery, geriatrics, pediatrics, gynecology.

Alumni will gather at pre-arranged places,
To relive old times and to check on old faces.
There'll be too, a session on new legislation,
On how to keep MEDICARE out of the nation.

The future of medicine's looking quite grey,
With such help as we've had from our friend JFK.
MAG gives us a means for correction —
Remember to vote in the coming election.

There'll be time to spare for plenty of fun—
To swim in the ocean and lie in the sun.
For golfers, a beautiful course and some prizes;
Fisherman, come catch those fish of all sizes!

Apologies, colleagues, for this ailing rhyme!
It might have been better if I'd had more time;
Nevertheless, it's worth coming miles
To bask in the pleasures of these Golden Isles.

*Ben T. Galloway, M.D.
President, Glynn County Medical Society*

New Aspects of Therapy for Severe Pancreatitis

WITH THE PASSAGE OF TIME, the frequency with which acute pancreatitis is diagnosed without surgery has increased markedly, from 15 per cent in 1950 to 55 per cent in 1960. This has most likely been due to better diagnostic tests, as well as to a greater awareness of the disease process. More facts and fewer postulates are now generally known about the various causes of the disease, its natural course, and its treatment.

The majority of patients in whom the diagnosis of acute pancreatitis is made are not desperately ill and respond well to the usual measures of gastrointestinal rest and fluid replacement. There is a small group, however, which goes on to develop a fulminating hemorrhagic pancreatitis and, in this group, there is a distressingly high mortality, reaching 80-90 per cent in many series. It is imperative, therefore, to recognize this latter group of patients as early as possible and to then administer the heroic measures necessary to salvage a greater number. These measures are often not completely innocuous however, and should be used judiciously in those patients who do not have clear-cut evidence of a fulminating disease.

Evidence

The best evidence for this situation is as follows: (1) The early development of severe ileus with marked abdominal distention and the accumulation of free fluid within the abdomen. (2) The presence of shock associated with the loss of large quantities of blood and plasma from the vascular bed. (3) Subsequent renal failure with oliguria and azotemia. (4) Marked electrolyte abnormalities and of special importance is the pronounced drop in serum calcium with its attendant tetany. (5) The development of an abdominal mass, whether it be pancreatic pseudocyst, abscess, or large areas of fat necrosis which remain sterile.

When the fulminating disease is present, extreme measures are mandatory for any hope of survival. The quantities of fluid, plasma and blood required are similar to those needed in the treatment of massive burns of 50-60 per cent of the body surface. The most useful index of this loss is by the repeated

calculation of the vascular components with radioactive blood volume determinations.

Serum calcium is lost by its combination with the fatty acids which have been released from the injured pancreas. This loss can be of large magnitude and continues for days or even weeks. The administration of large quantities of intravenous calcium gluconate by continuous intravenous drip during this period is essential if tetany is to be avoided. Ten to 15 ampules in a 24-hour period may be required in the patient with fulminating pancreatitis.

Antibiotics

The empirical use of antibiotics is often questioned in the treatment of pancreatitis since the initial process is not infectious. However, in the group being considered, septic complications are common (i.e. pulmonary or retroperitoneal infections) and the early and vigorous use of antibiotics seems mandatory. Where specific sensitivities are known, the use of the appropriate antibiotic is wise; otherwise, large doses of broad spectrum antibiotics are indicated.

Use of the steroids has been advised by some and condemned by others in the treatment of the general collapse seen with the fulminating disease. Certainly, their use complicates an already complex problem of infection, electrolyte imbalance and carbohydrate metabolism — but the patient may be supported by cortisone in an otherwise lethal period and it should not be denied him.

Finally, for consideration in the treatment of this situation in the near future, there is a proteolytic enzyme inhibitor (Trasyol — Bayer A-128) which has had encouraging results in preventing the activation of proteolytic enzymes (trypsin, chymotrypsin, and fibrinolysin) in the pancreas and in the survival rates of experimental animals. There is some evidence that this inhibitor may also block the action of hypotension — producing substances released from the diseased pancreas. This material is not generally available as yet, but may prove to be effective in preventing the development of the lethal form of this disease.

Harrison L. Rogers, Jr., M.D.

Could This Be Yours?

SOME FOUR MONTHS ago a patient was admitted to a Georgia hospital with a diagnostic problem. The case soon came to operation, and complete recovery from the original condition was effected.

However, while hospitalized, the patient received a preparation containing one half gram of streptomycin twice daily for 12 days. A month later secondary hearing symptoms were noticed. The patient is now seen with a marked hearing loss and the resulting voice changes, complaining of increasingly annoying ear noises. A seriously handicapped person.

Examination

Examination finds: anatomically normal ear, nose and throat; ocular fundi; visual fields; blood pressure etc. Neurological examination finds nothing of significance, except for the eighth nerve symptoms. An audiogram indicates the expected, bilateral nerve type deafness, for which a hearing aid is of no value,

and for which nothing helpful can be done, either medically or surgically.

While this patient received a fairly large dosage, eighth nerve damage has followed a single $\frac{1}{2}$ gram dose. The symptoms, of vertigo or ear noise and deafness, do not necessarily become immediately apparent. In this, as in most cases, neither the administering physician nor the patient is aware of any drug-symptom relationship.

Selective neuro-toxicity of streptomycin and of dihydrostreptomycin for the eighth nerve complex is an unfortunate fact, a fact that must be recognized and acknowledged. Toxicity from these drugs is unpredictable in occurrence, non-responsive to treatment, frequently nonreversible in character, seriously disabling, and more frequently than generally recognized. The use of drugs so valuable in therapeutics yet potentially so disablingly harmful, must be reserved for cases in which they are specific, necessary, and irreplaceable.

Henry R. Perkins, M.D.

MENTAL HEALTH HEAD APPOINTED

Climaxing a three year search, Dr. Addison M. Duval, a Virginia psychiatrist, has accepted the post of Director of the Division of Mental Health, Georgia Department of Public Health. He will assume his new duties on or about March 1.

Dr. Duval's job will be a big and challenging one. He will have the responsibility for planning and supervising the continuing development of Georgia's mental health program.

He will also have general supervision of: Milledgeville State Hospital, Gracewood State School and Hospital, Alcoholic Rehabilitation Service and Community Mental Health Service, all of which are under the administration of the State Health Department.

When it is completed, the Georgia Mental Health Center will be added to this list, as well as any other mental health programs which may come under the State Health Department.

A highly qualified psychiatrist and administrator, Dr. Duval is a native Virginian, being born in Rhoadesville,

Virginia. Since January 1, 1962, he has served as Director of Training and Research at Eastern State Hospital, Williamsburg, Virginia. Prior to that assignment he was Director, Missouri Division of Mental Diseases.

Dr. Duval attended the University of Richmond and received his M.D. degree from the Medical College of Virginia in 1929. He interned and received his basic psychiatric training at St. Elizabeth's Hospital, Washington, D. C. He was appointed to the permanent staff of that institution in 1930. After promotion to Assistant Superintendent of St. Elizabeth's in 1953, he left this position in 1959 to assume his duties in Missouri.

Dr. Duval is treasurer and a member of the Executive Committee of the American Psychiatric Association.

Married to the former Elizabeth Weymouth, Dr. and Mrs. Duval have two children, Martha Duval Swartwout and Robert Cammack Duval. The Duvals will make their home in Atlanta.

109th Annual Session Official Call

Extended to All Officers and Members of the Medical Association of Georgia

THE 109th Annual Session of the Medical Association of Georgia will be convened at the Aquarama, Jekyll Island, Georgia, on May 5, 6, 7, and 8, 1963.

The MAG Official Registration Desk will be located at the entrance to the Aquarama which will house the Scientific Exhibits, Commercial Exhibits, main Scientific Meeting Hall, MAG Headquarters Office and Press Room. Registration for Association members and guests will be conducted Sunday, May 5, from 1:00 P.M. to 6:00 P.M.; Monday, May 6, from 8:00 A.M. to 12:00 NOON; and Tuesday, May 7, from 8:00 A.M. to 5:00 P.M.

MAG General Business Sessions

The Association will convene the First General Business Session Sunday, May 5, at 2:00 P.M., in the Aquarama Meeting Hall for the purpose of nominations to MAG Offices and Awards. The Second General Business Session will be held Monday, May 6, at 12:00 NOON, in the Aquarama Meeting Hall at which time the outgoing MAG President will make his report to the membership, and the MAG President-Elect will outline his program for the coming year during which he will preside as MAG President. The Third General Business Session is set for Wednesday, May 8, at 11:00 A.M., in the Aquarama Meeting Hall. At this meeting, MAG Awards will be presented, new MAG Officers will be installed, and the entire Annual Session will be adjourned at approximately 12:00 NOON.

MAG House of Delegates

The First Session of the Association House of Delegates will be convened Sunday, May 5, at 5:00 P.M., in the Aquarama Meeting Hall at which time reports and resolutions will be introduced to the House for referral to House Reference Committees. Also scheduled for the Delegates at this session will be an address by James W. Harkess, M.D., Augusta, formerly of Edinburgh, Scotland. Dr. Harkess' address is entitled, "Socialized Medicine." All MAG

members, Auxiliary members and guests are invited to attend this session.

Immediately following this First Session of the House, all Delegates are cordially invited to attend the traditional MAG Delegates and Exhibitors Social Hour scheduled for 6:30 P.M., in the Buccaneer Motel.

House Reference Committees will convene Monday morning and Monday afternoon, May 6, in the Rotunda of the Aquarama to make recommendations to the House on all reports and resolutions. Delegates and all members are welcome to appear before these Reference Committees on issues presented to the House. Reference Committee meeting times and meeting places are also published in the Program and in the House of Delegates Handbook.

The Second and Final Session of the House of Delegates will be held Wednesday, May 8, at 9:00 A.M., in the Aquarama Meeting Hall. Reference Committees will present their recommendations on all reports and resolutions before the House and final action on this business will be voted by the members of the House.

All MAG members, Auxiliary members and their guests are welcome to attend these sessions of the House of Delegates.

Scientific Meetings

MAG Scientific Section and Joint Section Meetings are scheduled for Sunday afternoon, May 5, from 2:30 P.M. to 5:00 P.M.; Monday morning, May 6, from 9:00 A.M. to 12:00 NOON, Tuesday morning, May 7, from 9:00 A.M. to 12:00 NOON, and again Tuesday afternoon, May 7 from 2:30 P.M. to 5:00 P.M.

The Abner W. Calhoun Memorial Lectureship is scheduled to be held Tuesday, May 7, from 12:00 NOON to 1:00 P.M. in the Aquarama Meeting Hall. There will be no Official MAG Section or Joint Section Meetings scheduled for Monday afternoon, May 6. Meeting Rooms for each MAG Section or Joint Section Meetings are noted on page 112 in the MAG Program Resume and in the complete program on the following pages.

MAG PROGRAM RESUME

Sunday, May 5

- 2:00 P.M. MAG General Business Session, *Aquarama*
- 2:30 P.M. Psychiatry, General Practice, Medicine, Dermatology, Diabetes and Chest Joint Section Meeting, *Aquarama*
- 2:30 P.M. Anesthesiology and Orthopedics Joint Section Meeting, *Ballroom, *Stuckey's Carriage Inn*
- 2:30 P.M. Radiology Section Meeting, *Corsair Motel*
- 5:00 P.M. MAG First Session House of Delegates, *Aquarama*
- 6:30 P.M. MAG Delegates and Exhibitors Social Hour, *Buccaneer Motel*

Monday, May 6

- 8:00 A.M. MAG House of Delegates Reference Committee, No. 1, No. 2, and No. 3, *Rotunda Aquarama*
- 9:00 A.M. Psychiatry, Medicine, Dermatology, Diabetes, and Chest Joint Section Meeting, *Aquarama*
- 9:00 A.M. Surgery, Orthopedics and Anesthesiology

*Formerly Holiday Inn

Joint Section Meeting, *Ballroom, Stuckey's Carriage Inn*

- 9:00 A.M. Obstetrics and Gynecology, Urology and Radiology Joint Section Meeting, *Room 3 and 4, Stuckey's Carriage Inn*
- 9:00 A.M. Pathology Section Meeting, *Sky Room, Wanderer Motel*
- 12:00 NOON MAG General Business Session, *Aquarama*
- 2:30 P.M. MAG House of Delegates Reference Committee No. 4 and No. 5, *Rotunda Aquarama*

Tuesday, May 7

- 9:00 A.M. MAG General Scientific Session (G.P. Day), *Aquarama*
- 12:00 NOON Abner W. Calhoun Memorial Scientific Lectureship, *Aquarama*
- 2:30 P.M. Surgery and Medicine Joint Section Meeting, *Aquarama*
- 2:30 P.M. Obstetrics and Gynecology Section Meeting, *Ballroom, Stuckey's Carriage Inn*

Wednesday, May 8

- 9:00 A.M. MAG Second Session House of Delegates, *Aquarama*
- 11:00 A.M. MAG Final General Business Session, *Aquarama*

Specific Information

Registration

The Medical Association of Georgia official Registration Desk will be located at the entrance to the Aquarama. The desk will be adjacent to the entrance and exit for Scientific Exhibits, Commercial Exhibits and the main Scientific Meeting Hall in the Aquarama. The desk will be open for registration of MAG members and guests on Sunday, May 5, from 1:00 P.M. to 6:00 P.M.; Monday, May 6, from 8:00 A.M. to 12:00 NOON; and Tuesday, May 7 from 8:00 A.M. to 5:00 P.M.

MAG members and guests are requested to register at the MAG Registration Desk *immediately on arrival* at the Aquarama to obtain badges and programs. *No one will be admitted* to the Exhibit Halls and Meeting Rooms without official registration badges.

Message Center

A Message Center will be maintained at the MAG Official Registration Desk for the convenience of the membership. Pages from the Woman's Auxiliary to MAG will staff this center during the entire session. All notices of an official nature will be posted on the Official Bulletin Board at the Message Center adjacent to the MAG Registration Desk.

MAG Headquarters Office and Press Room

The MAG Headquarters Office Staff will maintain

a Headquarters Office Room at the Aquarama for the purpose of secretarial staff activity in conjunction with the conduct of Association business during the meeting.

An MAG Press Room will also be available for use by newspaper, radio and television media personnel during the entire Annual Session. The Press Room will be adjacent to the MAG Headquarters Office in the Aquarama.

MAG House of Delegates

The MAG House of Delegates will convene Sunday afternoon, May 5 at 5:00 P.M. in the Aquarama Meeting Hall. MAG Delegates will reconvene for the Second Session of the House of Delegates on Wednesday, May 8 at 9:00 A.M. again in the Aquarama Meeting Room.

All MAG Delegates are requested to attend both of these sessions of the House *at least 15 minutes prior to the time when they convene* so that the Delegates may be registered without delay of these meetings. Special Delegates Registration, for both Sessions of the House, will be conducted just outside the entrance to the Aquarama Meeting Room, where the Delegates are scheduled to meet. During this registration, Delegates' credentials are checked and Delegates are given special registration badges which

certify the Delegate's right of vote during the sessions of the House.

MAG Memorial Service

The Medical Association of Georgia will hold its annual Memorial Service at the First Session of the House of Delegates on Sunday afternoon, May 5, at 5:00 P.M. in the Aquarama Meeting Room. All members and guests are cordially invited to attend this service which is held in memory of the members who have died during the past year. The event will honor the service and contributions of the following medical practitioners:

- Guy D. Ayers, Madison, Florida, July 21, 1962
- James B. Baird, Atlanta, December 1, 1962
- Marion Trotti Benson, Atlanta, June 7, 1962
- J. H. Boland, Atlanta, February 9, 1963
- Wade H. Born, McRae, August 24, 1962
- U. S. Bowen, Los Angeles, California, January 24, 1963
- Reese W. Bradford, Columbia, South Carolina, September 1, 1962
- Harry Langdon Cheves, Sr., Union Point, September 29, 1962
- M. B. Copeloff, Atlanta, February 12, 1963
- R. D. Crone, Athens, February 25, 1962
- Alton Walker Davis, Warrenton, October 7, 1962
- Edgar Brown Davis, Byromville, November 20, 1962
- N. M. DeVaughn, Augusta, December 12, 1962
- John Baxter Duncan, Atlanta, May 15, 1962
- R. E. L. English, Griffin, July 1, 1962
- W. P. Ezzard, Lawrenceville, January 29, 1963
- J. A. Faulkner, Augusta, January 11, 1963
- Kimsey E. Foster, College Park, October 9, 1962
- Thomas Norman Freeman, Jr., LaGrange, June 3, 1962
- John S. Gibson, Atlanta, July 30, 1962
- Warren Walter Gremmel, Atlanta, April 1, 1962
- Hugh Hailey, Atlanta, January 13, 1963
- Frederick W. Hames, Cumming, September 16, 1962
- William R. Hodges, Thomasville, February 11, 1963
- Louis Holtz, Carrollton, September 27, 1962
- Arthur Lee Horton, Cartersville, May 4, 1962
- Paul Lovejoy Hudson, Atlanta, February 11, 1962
- Andrew Jackson Jones, Jacksonville, June 2, 1962
- Carl A. Kline, Griffin, June 24, 1962
- Thomas E. McBryde, Rockmart, July 3, 1962
- Christopher J. McLoughlin, Atlanta, June 4, 1962
- J. L. Meeks, Gainesville, January 7, 1963
- Joyce F. Mixson, Sr., Valdosta, January 11, 1963
- Henry H. Olliff, Sr., Register, April 12, 1962
- DeWitt Pritchett, Barnesville, October 5, 1962
- John D. Stillwell, Thomasville, January 7, 1963
- J. C. Stone, Doerun, May 15, 1962
- James Andrew Thrash, Columbus, May 21, 1962
- Charles Usher, Savannah, May 13, 1962
- Emmett Ward, Ellenwood, October 4, 1962
- George Atticus Ward, Sr., Elberton, February 25, 1962
- Samuel DeWaite Work, Jr., Macon, September 10, 1962
- James Clement Woolridge, Columbus, September 7, 1962
- Samuel Youngblood, Jr., Savannah, August 13, 1962

Specialty Society Meetings, Luncheons and Dinners

Specialty Societies have planned meetings, luncheons and dinners for the membership of their organ-

izations to be held in conjunction with the MAG Annual Session. These events are listed in the Official MAG Program in the order of the date and the time the event is scheduled—under *Social Events*. As these sessions are limited to the membership of the specialty society sponsoring the affair, they are not considered a part of the Official MAG Program.

Woman's Auxiliary to MAG

The Woman's Auxiliary to the Medical Association of Georgia will convene their 38th Annual Meeting in conjunction with the MAG Annual Session. The Auxiliary Registration Desk and meetings will be in the Buccaneer Motel. The complete program giving times, dates and locations of Auxiliary meetings, activities and functions will be found in this issue immediately following the program material of the MAG.

Social Events

Information about social events planned in conjunction with the MAG Annual Session and the necessary admission tickets will be available at the MAG Official Registration Desk. As accommodations for such social events are limited, *your cooperation in purchasing tickets at the time of your registration is requested*. The traditional Alumni banquets and other banquet tickets may be arranged at the Registration Desk.

Scientific Exhibits

Scientific Exhibits will be displayed adjacent to the Commercial Exhibits in the Aquarama. The Scientific Exhibits are prepared by physicians who will be at their exhibits to discuss these presentations with the membership. All physicians are urged to visit each Scientific Exhibit in the interests of professional education. Awards for outstanding Scientific Exhibits will be presented at the MAG Final General Business Session on Wednesday, May 8, at 11:00 A.M. in the Aquarama Meeting Room.

Commercial Exhibits

Approximately 45 Commercial Exhibits will be displayed in exhibit booths in the corridor entrance to the Main Meeting Hall of the Aquarama just adjacent to the MAG Registration Desk. These exhibits will provide technical information of importance on the latest products and services available to the medical profession.

It is extremely important that every member visit each of these exhibits and register with the exhibitor. Your cooperation is requested since these displays are designed and shown specifically to benefit the profession.

The Commercial Exhibitor plays an extremely important role in making the MAG Annual Session

possible and the Association Commercial Exhibits Committee strongly urges your participation in this area of MAG activity. *Please be sure to visit each and every Commercial Exhibit booth.* A list of the Commercial Exhibitors already participating at this time in the MAG Annual Session is as follows:

Booth

No.	Name of Firm
1	Johnson & Johnson, New Brunswick, N. J.
2	G. D. Searle & Company, Chicago, Ill.
3	Marion Laboratories, Inc., Kansas City, Mo.
4	Schering Corporation, Bloomfield, N. J.
5	Roche Laboratories, Nutley, N. J.
6	Sandoz Pharmaceuticals, Hanover, N. J.
7	The Borden Company, New York, N. Y.
8	The Wm. S. Merrell Company, Cincinnati, Ohio
9	Ciba Pharmaceutical Company, Summit, N. J.
10	Knoll Pharmaceutical Company, Orange, N. J.
11	Charles C. Haskell & Company, Richmond, Va.
12	Loma Linda Food Company, Arlington, Calif.
13	A. H. Robins Company, Inc., Richmond, Va.
14	Medco Products Company, Inc., Tulsa, Okla. R. R. Pruitt, Distributor, Atlanta 10, Ga.
15	Hart Laboratories, Winston-Salem, N. C.
16	Warner-Chilcott Laboratories, Morris Plains, N. J.
18	Mead Johnson Laboratories, Evansville, Ind.
19	William P. Poythress & Company, Richmond, Va.
20	Parke, Davis & Company, Detroit, Mich.
21	Van Pelt and Brown, Richmond, Va.
22	Organon, Inc., Orange, N. J.
23	Poole & Wood Associates, Atlanta, Georgia
24	J. B. Roerig and Company, New York, N. Y.
27	Wachtels Physician Supply Company, Savannah, Ga.
28	U. S. Vitamin & Pharmaceutical Corp., New York, N. Y.
29	Geigy Pharmaceuticals, Yonkers, N. Y.
30	Delta Drug Corporation (A Ga. Corp.), Sa- vannah, Ga.
32	Lloyd, Dabney & Westerfield, Inc., Cincinnati, Ohio
36	The Warren-Teed Products Company, Colum- bus, Ohio
37	Great Books of the Western World
38	Carnation Company, Los Angeles, Calif.
39	The Coca-Cola Company, Atlanta, Ga.
40	International Latex Corporation, New York, N. Y.
43	The Upjohn Company, Kalamazoo, Mich.
44	Merck Sharp & Dohme, Philadelphia, Penn.
49	Life Insurance Company of Georgia, Atlanta, Ga.
50	Pfizer Laboratories, Brooklyn, N. Y.

- 51 Abbott Laboratories, N. Chicago, Ill.
- 52 E. R. Squibb & Sons, New York, N. Y.

Fifty-Year Members

Physicians who have practiced medicine for 50 years will be honored at the MAG Annual Session by the award of a 50-year Pin and Certificate. These awards will be presented at the MAG Final General Business Session on Wednesday, May 8, at 11:00 A.M. in the Aquarama Meeting Room. The following list contains the names of all of the members of the Medical Association of Georgia who, as of the year 1963, have practiced medicine 50 years. It does not record the names of physicians who have already received gold membership cards. This is the class of 1913, as follows:

Robert H. Bradley	Chatsworth
Ruben Thornton Camp	Fairburn
Ernest Stewart Colvin	Atlanta
Charles Henry Dickens	Madison
Ward Beecher DuVall	Atlanta
Thomas Mixon Ezzard	Roswell
Kimsey E. Foster (deceased)	College Park
Thomas Pope Goodwyn	Atlanta
John H. Grubbs	Molena
Wm. Arthur Hodges	Atlanta
Cornelius F. Holton	Savannah
Arthur L. Horton (deceased)	Cartersville
Albert Sidney Johnson, Sr.	Elberton
Osee F. Keen	Macon
Fleming D. Kennedy	Baxley
Harry Nelson Kraft	Atlanta
C. J. Maloy	McRae
Robert H. McDonald	Newnan
Jos. Eugene Mercer	Vidalia
Mark P. Pentecost	Marietta
Carl S. Pittman, Sr.	Tifton
DeWitt W. Pritchett (deceased)	Barnesville
Willis Eugene Ragan	Atlanta
George A. Ward (deceased)	Elberton
Loron Earl Williams	Cordele

Golf Activities

An open tournament has been arranged for MAG members at the Jekyll Island Golf Club on the following dates: Sunday, May 5 — all day; Monday, May 6 — all day; and Tuesday, May 7 — morning only. Physicians wishing to participate should identify themselves as MAG members and *turn in their score card to the Club Pro marked MAG* so that the MAG Golf Committee may total scores for prize awards. Golf tourney prizes will be awarded at the President's Banquet, Tuesday evening, May 7.

Other golf courses available for non-tourney play include Brunswick Country Club and the Sea Island Golf Club on St. Simons Island.

GUEST SPEAKERS



PRISCILLA WHITE, M.D.

Boston, Massachusetts

PRISCILLA WHITE, M.D., of Boston, Massachusetts, will open one of the first scientific sections of the 109th Annual Session of the Medical Association of Georgia on Sunday, May 5 at 2:30 P.M. Dr. White will present a paper entitled, "Present Day Management of Diabetes," to the Psychiatry, General Practice, Medicine, Dermatology, Diabetes and Chest Joint Section Meeting. On Monday, May 6 at 10:00 A.M., Dr. White will present a second paper on, "Pregnancy Diabetes." This will be given to the Psychiatry, Medicine, Dermatology, Diabetes and Chest Joint Section Meeting.

Tufts Medical Degree

Dr. White received her medical degree from the Tufts University Medical School, where she has served as Assistant Professor of Pediatrics. She has served as Physician at the Joslin Clinic, New England Deaconess Hospital, Faulkner Hospital, Boston Lying-in Hospital and as a Consultant at the Boston Floating Hospital and the New England Hospital.

She is a member of the American Diabetes Association and the N. E. Diabetes Association, and is an honorary member of the Royal Belgian Society of Obstetrics and Gynecology.

Banting Memorial Lecture

Dr. White has published numerous articles for medical and scientific journals in addition to delivering the 1960 Banting Memorial Lecture, American Diabetes Association, where she was awarded the Banting Medal, the highest scientific recognition that that organization can confer. Priscilla White was the first woman to be invited to give the Banting Lecture and has the distinction of being the first woman elected to the Council of the Association.



ELTON WATKINS, JR., M.D.

Boston, Massachusetts

ELTON WATKINS, JR., M.D., a native of Portland, Oregon, and a current resident of Boston, Massachusetts, was graduated from the University of Oregon Medical School. He is at present Consultant in Surgery and Physiology, U. S. Naval Hospital, Chelsea, Massachusetts; Assistant in Surgery, Peter Bent Brigham Hospital, Boston; Surgeon Lathrop Clinic, Boston, and on the surgical staffs of New England Deaconess Hospital, New England Baptist Hospital, and the Brooks Hospital, all at Boston. He is now serving as Consultant in Medical Sciences, Avco Research and Advanced Development Center, Wilmington, Massachusetts. He is certified by the American Board of Surgery and the Board of Thoracic Surgery, and is a fellow of the American College of Surgeons, a member of the Pan-pacific Surgical Association, a fellow of the American College of Chest Physicians, and a member of the International Cardiovascular Society, the American Thoracic Society, the American Federation of Clinical Research, and the American Association for the Advancement of Science.

Dr. Watkins will present a paper, "Regional Cancer Chemotherapy," to the Psychiatry, General Practice, Medicine, Dermatology, Diabetes and Chest Joint Section Meeting on Sunday, May 5 at 3:00 P.M. On Monday, May 6 at 10:30 A.M. he will present the same paper to the Psychiatry, Medicine, Dermatology, Diabetes and Chest Joint Section Meeting. An abstract of the paper follows:

A method of regional cancer chemotherapy is presented which embodies the continuous arterial infusion using a suitable infusion pump of an anticancer chemical through a catheter inserted into a known site in the arterial blood supply of advanced cancer. The compound is arterially infused in suprellethal doses in order to obtain a continuous high concentration of the antitumor drug in the area of therapy. In order to combat generalized toxicity which might develop when the antitumor chemical returns via the veins to the general circulation of the rest of the body, the specific antidote is administered intramuscularly. Continuous, around-the-clock infusion therapy is given for periods of one to four weeks.

ALEXANDER H. WOODS, M.D.

Oklahoma City, Oklahoma

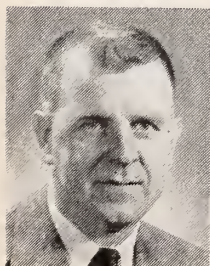
ALEXANDER H. WOODS, M.D., Oklahoma City, Oklahoma, will present his first paper of the session to the Psychiatry, General Practice, Medicine, Dermatology, Diabetes and Chest Joint Section Meeting on Sunday, May 5 at 3:30 P.M. "Bone Marrow Autografts and Homografts in Man," concerns:

Modern concepts of immunology dating back approximately ten years. During this time a body of fundamental information concerning homografts has been accumulated in animals. Numerous attempts to carry this over to man have been made, generally without success. The current situation with regard to bone marrow grafts will be scrutinized and its prospects estimated.

"Biological Dosimetry" will be presented Monday, May 6 at 11:00 A.M. before the Psychiatry, Medicine, Dermatology, Diabetes and Chest Joint Section Meeting. A summary of the paper is as follows:

Tissue injury by ionizing radiation produces varying clinical pictures depending upon the dose and type of radiation. Also, a factor of varying individual sensitivity to radiation enters in. Unfortunately, the full effect of radiation may not become apparent for two weeks after exposure. A method for early and reliable detection of tissue injury is urgently required with the increasing number of accidental exposures and the threat of nuclear war. Present research in this area will be discussed and one method presented in some detail.

Dr. Woods received his medical degree from Johns Hopkins, where he also served his internship. Three years of residency and two years as a research fellow in biochemistry were served at Duke University Hospital. Dr. Woods came to Oklahoma as a VA Clinical Investigator in 1958 and has since become Assistant Professor of Medicine and Assistant Professor of Microbiology (Immunology) at the University of Oklahoma School of Medicine.



ROBERT L. MAYOCK, M.D.

Philadelphia, Pennsylvania

"METABOLIC Aspects of Pulmonary Disease," will be the first scientific paper presented by ROBERT L. MAYOCK, M.D., of Philadelphia. Dr.

Mayock will present his paper on Sunday, May 5 at 4:00 P.M., before the Joint Section Meeting of Psychiatry, General Practice, Medicine, Dermatology, Diabetes and Chest. A precis of the paper follows:

Pulmonary disease produces metabolic effects not only through interfering with respiration but also through direct effects on metabolism. Many metabolic diseases have a secondary effect on the lungs. Some of the metabolic disturbances associated with pulmonary disease are, hypercalcemia with metastases, Cushing's syndrome in carcinoma of the lung, hypoglycemia with intrathoracic tumors, carcinoid syndrome, and the inappropriate ADH response seen with many lung tumors.

Metabolic diseases having effects on respiration are those of the liver, muscular system, skeletal system and the peripheral nervous system. Other diseases affecting respiration are hyperthyroidism, hypokalemia, metabolic acidosis, obesity and cystic fibrosis.

At 9:30 A.M. on Monday, May 6, Dr. Mayock will present to the Psychiatry, Medicine, Dermatology, Diabetes, and Chest Joint Section Meeting, a paper entitled, "Chemoprophylaxis of Tuberculosis." A short summary follows:

The uses of chemotherapy in active tuberculosis today is unquestioned. Our major decisions are in the uses of chemotherapy in persons with inactive disease, with disease of unknown activity, with recent tuberculin conversion, with disease or therapy associated with increased susceptibility to tuberculosis, and with an excessive exposure despite a negative tuberculin skin test. Recent studies and evaluations have given us better bases for making these decisions in given communities and the indication for the uses of chemoprophylaxis are gradually becoming well delineated.

University of Pennsylvania

Dr. Mayock received his B.S. degree in biology from Bucknell University and his medical degree from the University of Pennsylvania Medical School. He served an internship and residency at the Hospital of the University of Pennsylvania. He is at present Chief of the Pulmonary Disease Section at both the Hospital of the University of Pennsylvania and the Philadelphia General Hospital. Dr. Mayock is certified by the American Board of Internal Medicine and is a member of the American Association for the Advancement of Science, American Trudeau Society, American Federation for Clinical Research, and is a fellow in the American College of Physicians and the American College of Chest Physicians.

LAMAR S. OSMENT, M.D.

Birmingham, Alabama



SPEAKING to the Psychiatry, General Practice, Medicine, Dermatology, Diabetes, and Chest Joint Section Meeting on Sunday, May 5 at 4:30 P.M., on the subject of, "Lupus Erythematosus," will be LAMAR S. OSMENT, M.D., of the University of Alabama Medical Center, Birmingham, Alabama. On Tuesday, May 7 at 9:00 A.M. Dr. Osment will present a paper entitled, "Topical Treatment for Skin Diseases," to the G. P. Day—General Session.

Dr. Osment is a graduate of Birmingham Southern College and the Medical College of Alabama and is at present Associate Professor of Dermatology, University of Alabama Medical Center. He is certified by the American Board of Dermatology, was from 1958-1959 the President of the Alabama Dermatological Society, and from 1960-61 the Vice-president of the Southeastern Dermatological Association. Dr. Osment has published numerous papers in the field of Dermatology.

A precis of the paper, "Lupus Erythematosus," to be presented May 5 is given below:

There has been considerable interest recently in a group of disorders in which anti-tissue antibodies called auto-antibodies can be demonstrated. The demonstration of auto-antibodies is most easily done in the laboratory as immunological tests.

The collagen diseases including lupus erythematosus and others are such disorders. Systemic lupus erythematosus patients show anti-nuclear antibodies, biologic false positive reactions for syphilis, L.E. cells, positive intradermal skin reactions to leukocytes and many also have positive latex tests. Chronic discoid lupus erythematosus is a more benign disorder and infrequently progresses to the systemic form. However, many patients with discoid lupus have immunological manifestations characteristic of systemic lupus erythematosus.

A short summary of the paper, "Topical Treatment for Skin Diseases," to be given at 9:00 A.M. May 7 follows:

For the practitioner treating skin diseases there is always a best way of prescribing for the individual patient. Topical agents for use in the treatment of skin diseases are numerous. Many active pharmaceuticals are available in a wide variety of strengths, vehicles, and sizes of packages. Also, there are several varieties of agents offered for the treatment of any given disorder.

A summary has been prepared describing the properties and uses of ointments, creams, lotions, sprays, compresses, and other topicals. Specific active ingredients include the topical antibiotics,

anesthetics, antipruritics, antiseborrheics, acne medications, antifungals, as well as solutions for compresses, and keratolytics as used in callositas. Some specific agents should not be used on the skin. Also, some are more effective or less irritating than others.

B. W. ARMSTRONG, M.D.

Charlotte, North Carolina



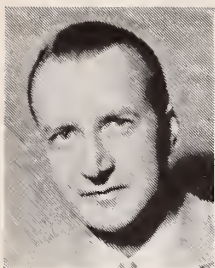
SUNDAY, May 5 at 2:45 P.M., DR. B. W. ARMSTRONG of Charlotte, North Carolina, will speak to the Pediatrics and EENT Joint Section Meeting on the subject of, "Secretory Otitis Media." Following is a brief summation of the paper:

Secretory otitis media is by far the most common cause of impaired hearing in children. The diagnosis may be established without difficulty in most instances, but too often it can be overlooked if one is not looking for fluid in *every* ear examined. It is easy to be misled by the history, physical examination, and the usual hearing tests. The history may not include anything that leads one to suspect a disorder in the ear, the physical examination may not be characteristic, and the hearing loss may range from mild to severe. Treatment must be directed toward the basic disease process and restoring the normal function of the eustachian tube.

At 10:00 A.M. on Tuesday, May 7, Dr. Armstrong will speak to the G. P. Day—General Session on, "Vertigo—Differential Diagnosis and Treatment." Following is a short precis of the paper:

True vertigo is an experience of disordered orientation and must be differentiated from sinking spells, giddiness, swimmyheadedness, and other expressions loosely applied by patients to a wide variety of conditions. Ocular, central, and aural vertigo will be discussed.

Dr. Armstrong, whose practice is limited to otology, received both his B.A. and medical degrees from Syracuse University. He served an internship at Rochester General Hospital, Rochester, New York, served a fellowship in Otorhinolaryngology at the Lahey Clinic, Boston, and was a resident in Otology at Lempert Institute of Otology, New York, New York. He is presently associated with the Charlotte Eye, Ear and Throat Hospital in North Carolina. He is a member of the American Academy of Ophthalmology and Otolaryngology, the American Laryngological, Rhinological and Otological Society, American College of Surgeons, American Otological Society, and is a consultant for the North Carolina School for the Deaf.



EDWIN L. KENDIG, JR., M.D.

Richmond, Virginia

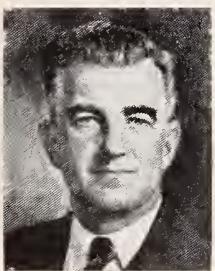
"TUBERCULOSIS in Children," will be the topic of the paper to be presented by **EDWIN L. KENDIG, JR., M.D.**, of Richmond, Virginia, to the Pediatrics and EENT Joint Section Meeting on Sunday, May 5 at 3:45 P.M.

A graduate of Hampden-Sydney College and the University of Virginia School of Medicine, Dr. Kendig received his hospital training at the Medical College of Virginia, Richmond; Bellevue Hospital, New York City; Johns Hopkins Hospital, Baltimore; and Babies Hospital, Wilmington, North Carolina. He is at present Associate Professor of Pediatrics, Medical College of Virginia, and Director, Child Chest Clinic, Medical College of Virginia Hospitals.

Following is a short summary of Dr. Kendig's paper:

Tuberculosis in childhood presents few, if any, symptoms unless the disease is far advanced. Diagnosis must be made by a routine tuberculin test applied some time during the first year of life or annually thereafter. Such a test is, of course, also advised whenever there is known contact with tuberculosis.

Pathogenesis, clinical features, and management of the various complications of the disease will be discussed.



AUSTIN T. MOORE, M.D.

Columbia, South Carolina

DR. AUSTIN T. MOORE of Columbia, South Carolina, will present two papers to the 109th Annual Session. On Sunday, May 5 at 3:30 P.M., he will speak to the Anesthesiology and Orthopedic Joint Section Meeting on, "Salvaging Problem Backs with Interbody and Posterior Arthrodeses," and on Monday, May 6 at 9:00 A.M., he will present a paper entitled, "Arthroplasty of Hip, Using Moore Prosthesis," to the Surgery, Orthopedics and Anesthesiology Joint Section Meeting.

A summary of, "Salvaging Problem Backs with Interbody and Posterior Arthrodeses," follows:

An explanation of how disk-like symptoms can

be due to irritated nerve roots and not to a disk protrusion will be discussed, and the fundamental principle of propping the vertebra apart will be outlined. The operation of multiprop and interbody fusion will be illustrated with slides. And, in severe cases, the use of the anterior retroperitoneal approach for interbody fusion will be outlined.

Dr. Moore, a graduate of Wofford College and the Medical College of the State of South Carolina, is a fellow of the American College of Surgeons, a member of the International College of Surgeons and the American Academy of Orthopedic Surgeons, is a diplomate of the Orthopedic Board, and is listed in Who's Who in America. He is currently Orthopedic Surgeon for the University of South Carolina; the South Carolina State Board of Health, Crippled Children's Division; and South Carolina State Hospital. He is Staff Orthopedic Surgeon for Columbia Hospital and Consultant Orthopedic Surgeon at Shaw Air Force Base Hospital, Shaw Air Force Base, South Carolina.

A short summation of Dr. Moore's second paper, to be presented Monday, May 6, follows:

A discussion of fracture of the hip, arthritis and various types of pathology outlining different types of treatment illustrated with a color and sound movie will be presented.



JOHN M. DENNIS, M.D.

Baltimore, Maryland

DR. JOHN M. DENNIS, Baltimore, Maryland, received his medical degree from the University of Maryland School of Medicine. An internship at the University of Maryland Hospital was followed by two years active duty with the U. S. Army. After a residency in radiology at the University of Maryland Hospital and a fellowship in radiology at the University of Pennsylvania Hospital, he was appointed to the Radiologic Staff of the University of Maryland Hospital and as an instructor in Radiology in the University of Maryland School of Medicine. In 1953 he was appointed Professor and Head of the Department of Radiology, University of Maryland School of Medicine.

Dr. Dennis has been Chairman of the Radiological Section of the Baltimore City Medical Society and President of the Maryland Radiological Society. He is currently Vice-president of the Maryland Division of the American Cancer Society and professional

delegate from Maryland to the American Cancer Society.

Dr. Dennis will present his first paper on Sunday, May 5 at 2:30 P.M. to the Radiology Section Meeting. A precis of, "Urinary Tract Infections in Infants and Children," follows:

Urinary infections and their consequences constitute a very large proportion of the urologic problems in children. These urinary infections in infants and children are often associated with obstructive lesions in the lower urinary tract which are difficult to diagnose unless urologists and radiologists are aware of them and cooperate closely, utilizing all diagnostic urinary procedures.

The importance of chronic recurring or persistent urinary tract infections in infants and children, the high incidence of associated obstructive lesions and the difficulties encountered in the diagnosis of these obstructive lesions and the severe sequelae of these urinary infections will be discussed. The relative merits of certain diagnostic procedures in studying these infections and associated obstructive lesions will be stressed.

A second paper, "Renovascular Hypertension," will be presented to the Obstetrics and Gynecology, Urology and Radiology Joint Section Meeting on Monday, May 6 at 10:00 A.M. A summary follows:

Approximately five per cent of the adult population in the United States is affected by hypertension, but a specific causative factor can be identified in only about ten per cent of these patients. It has been amply demonstrated, however, that occlusive disease of the renal arterial vasculature will produce hypertension which may simulate essential hypertension.

Many reports on the results of nephrectomy for hypertension has appeared in the literature. As recently as 1956 it was estimated that less than two per cent of all hypertensive patients were candidates for therapeutic renal surgery, but present diagnostic techniques for detecting renal vascular occlusive disease were not available at that time. Renal arteriography, individual kidney function studies and the radioactive renogram are now available to determine whether a renal vascular lesion is responsible for an individual case of hypertension. These procedures will be discussed as their proper utilization and interpretation will result in detecting an increased number of surgically correctable lesions.

J. GRAHAM SMITH, JR., M.D.

Durham, North Carolina



J. GRAHAM SMITH, JR., M.D., is Professor of Dermatology at the Duke University Medical Center, Durham, North Carolina, where he received his

B.S. and M.D. degrees. He was trained in Dermatology at Duke and the University of Miami. Author of over 50 articles, his primary investigative interests have been aging, particularly alterations in the connective tissue of skin associated with age and chronic sun damage. His memberships include the Society for Investigative Dermatology, the American Academy of Dermatology, the Gerontological Society and the American Dermatological Association.

Dr. Smith will present his first paper, "Aging Skin," on Monday, May 6 at 9:00 A.M., to the Psychiatry, Medicine, Dermatology, Diabetes and Chest Joint Section Meeting. Following is a summation:

What are commonly recognized as changes in human Caucasian skin are in reality predominantly effects of prolonged, repeated insults to the skin from the sun. Histochemical and biochemical investigations have demonstrated marked differences in the connective tissue of the dermis of unexposed aged skin compared with exposed aged skin.

With aging, non-fibrous protein and extractable collagen decrease while total collagen increases. The diminished extractability of collagen may be interpreted as evidence for increased cross-linking or polymerization of the collagen with age. While the total amount of collagen increases, there is a decrease in total acid mucopolysaccharide, particularly hyaluronic acid.

Chronically sun damaged skin, however, demonstrates an increase in non-fibrous protein and extractability of collagen with evidence of alteration or degradation of the collagen. Also, there is an increase in an elastin-like protein and increased total acid mucopolysaccharide, especially hyaluronic acid.

These findings in chronically sun damaged skin, notoriously susceptible to premalignant keratoses and basal cell epithelioma, cast serious doubt on the hypothesis that depolymerization of the collagen already present with an increase in acid mucopolysaccharide would be beneficial in altering the appearance of age in such skin.

It is concluded that the most effective approach in the alleviation of these changes of chronic sun damage lies in prevention or the replacement of the damaged dermis by procedures such as surgical planing or increasing the tautness of the skin via the classic plastic "face lift" procedure. Chemosurgery with caustics like phenol or trichloroacetic acid may be useful but their inherent danger suggests extreme caution.

On Tuesday, May 7 at 9:30 A.M., Dr. Smith will present his second paper to the G.P. Day—General Session. Following is a summary of, "Management of Common Dermatological Problems in the Southern United States":

Some of the most common skin problems encountered in the South result from flora, fauna, and climatological conditions peculiar to the area. The diagnosis and management of these including, poison ivy, insect bites, creeping eruption, sweat retention, Candidiasis, dermatophytosis, actinic keratosis, and basal cell epithelioma will be discussed.



JAMES W. OSBERG, JR., M.D.

Silver Spring, Maryland

JAMES W. OSBERG, JR., M.D., Director, Mental Health Study Center, National Institute of Mental Health, Adelphi, Maryland, attended the University of Virginia and Harvard University before graduating from Tufts College Medical School. His training in Psychiatry has included the U. S. Public Health service with subsequent assignments to Public Health Service Hospitals and to the National Institute of Mental Health; and as Director of Mental Health Services in the regional office of the Public Health Service, Atlanta, Georgia. He is a member of the American Public Health Association.

Dr. Osberg will present his paper, "The Role of the Physician in Community Mental Health," to the Psychiatry, Medicine, Dermatology, Diabetes and Chest Joint Section Meeting on Monday, May 6 at 11:30 A.M.. Following is a synopsis:

The paper will concern itself with a definition of community mental health and a discussion of the increasingly more visible role of the physician in mental health problems.

In terms of definition, the point of view will be taken that community mental health at this time is not a clearly defined area but is viewed variously by different professional and lay individuals depending upon their particular points of view and the setting in which they work. A brief historical sketch of the recent history in the field will be provided as a basis for a discussion of the role of the physician. Emphasis will be placed on the development of psychiatric services in general hospitals as a means by which psychiatrists are increasingly working closer with other physicians. Some attempt will be made to evaluate possible changes in patterns of medical care with respect to mental health problems.



ROBERT W. BUXTON, M.D.

Baltimore, Maryland

ROBERT W. BUXTON, M.D., of Baltimore, will present his first paper of the session to the Surgery, Orthopedic and Anesthesiology Joint Section Meet-

ing on Monday, May 6 at 9:30 A.M. A precis of, "Chemical and Metabolic Changes in the Traumatized Patient," follows:

The effects of and the reaction to varying degrees of injury in the human have been studied to some considerable extent but so often much of the data so collected is scattered in various Journals and is unavailable. We are attempting to study such patients, particularly those who develop post-trauma hypotension or shock. The paper will deal with some of these findings, particularly those whose correction or reversal has been shown to improve convalescence and survival.

His second paper, "Non-Penetrating Abdominal Trauma," will be given at 11:00 A.M. on Tuesday, May 7, at the G. P. Day—General Session. Following is the synopsis:

The danger of visceral rupture of fatal hemorrhage in a non-penetrating abdominal injury makes this one of the most important types of trauma and one in which correct early diagnosis and early proper intervention may make the difference between life and death.

Most detailed discussions of these injuries relate something of the history of the accident, the clinical localizing signs of specific organ injury, the laboratory and Roentgen signs and then suggest treatment.

Not rarely are these findings clear-cut and well defined. The operator may be astounded to find an entirely different, unanticipated injury upon celiotomy.

Several such instances are described and suggestions as to more precise preoperative diagnosis will be discussed.

Kansas Medical Degree

Dr. Buxton received his medical degree from Kansas University and served residencies in surgery at Genesee Hospital and Strong Memorial Hospital, Rochester, New York, and the University of Michigan. He has also served as Instructor in Thoracic Surgery at the University of Michigan and is presently Professor of Surgery at the University of Maryland. Dr. Buxton has contributed to many medical publications and is a diplomate of the American Board of Surgery, a fellow of the American College of Surgeons, and a member of the Society of University Surgeons, American Surgical Association, International Society of Angiology, International Society of Surgery, International Cardiovascular Society, and the Southeastern Surgical Congress.

KENNETH K. KEOWN, M.D.

Columbia, Missouri



DR. KENNETH K. KEOWN, Professor of Anesthesiology, School of Medicine, University of Missouri, received his medical degree from Hahnemann Medical College and Hospital of Philadelphia. He interned at Huron Road Hospital, Cleveland, Ohio, and was a resident in Anesthesiology at Hahnemann Medical College and Hospital, Philadelphia.

He is certified by the American Board of Anesthesiology and the American College of Anesthesiology. He is a member of the Southern Society of Anesthesiologists, American Society of Anesthesiologists, International Anesthesia Research Society, and the American Society for Advancement of Science. Dr. Keown served as Vice-chairman from 1955-1961 of the Board of Governors, American College of Anesthesiology, and is currently First Vice-president of the American Society of Anesthesiology, Secretary of the Section on Anesthesiology, American Medical Association; and President-elect of the Missouri Society of Anesthesiology. He received the Billings Award, American Medical Association in 1952 and is an honorary member of both the Cuban and Brazilian Societies of Anesthesiology.

A summary of his paper, "Preanesthetic Evaluation of Blood Loss in the Traumatized Patient," to be presented to the Surgery, Orthopedics and Anesthesiology Joint Section Meeting on Monday, May 6 at 10:00 A.M., follows:

Trauma is always accompanied by shock. The degree of shock depends upon the severity of the injury, duration of injury, degree of infection, previous physical status of the injured and the amount of deviation from the normal mechanisms of homeostasis.

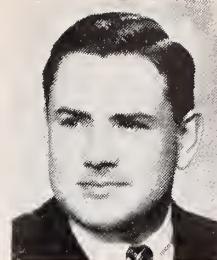
The shock syndrome following trauma may be oversimply defined as a progressive vasoconstriction, oligemia, hypoxia and tissue death. Stated anatomically, a discrepancy exists between the blood volume and the capacity of the vascular system.

Laboratory data pertinent to traumatized patients should include hematocrit, hemoglobin, blood volume determinations and a central venous pressure.

The clinical evaluation of the patient is the single most important estimation made by the anesthesiologist. Typically, immediately following surgery, the pulse rate is slow, and there is an elevation of the diastolic systemic blood pressure with a narrowing of the pulse pressure. Hypotension and tachycardia are late manifestations of the inadequacy of tissue perfusion.

ALBERT W. BIGGS, M.D.

Memphis, Tennessee



ALBERT W. BIGGS, M.D., Memphis, Tennessee, will present a paper entitled, "Control of Abnormal Prostatic Bleeding," on Monday, May 6 at 9:00 A.M., to the Joint Section Meeting of Obstetrics and Gynecology, Urology and Radiology.

Dr. Biggs received his medical degree from the University of Virginia Medical School, interned at North Carolina Baptist Hospital, Winston-Salem, North Carolina, and was assistant resident in pathology at Bowman Gray School of Medicine, Winston-Salem, N. C. He was a fellow of Medicine, New York University, Bellevue Medical Center, and a New York Heart Association Fellow, New York University, Bellevue Medical Center.

A short precis of Dr. Biggs' paper follows:

Patients who have developed acute, generalized fibrinolytic activity following prostatic manipulation or surgery, have been treated with intravenous fat emulsions with gratifying results. The fibrinolysis and bleeding have been controlled quite readily.

Presentation of cases and possible mechanisms of action will be discussed. Also, the results of work in progress on control of postoperative prostatic bleeding, not due to fibrinolysis, will be discussed.



LAWRENCE L. HESTER, JR., M.D.

Charleston, South Carolina

DR. LAWRENCE H. LESTER, Charleston, South Carolina, will present two papers at the Annual Session. The first on Monday, May 6 at 9:30 A.M., will be, "Carcinoma of the Cervix—Therapy and Complications," for the Obstetrics and Gynecology, Urology and Radiology Joint Section Meeting; and the second will be, "Fetal Distress," presented to the Obstetrics and Gynecology Section Meeting on Tuesday, May 7 at 2:30 P.M.

A short synopsis of the first paper follows:

"Carcinoma of the Cervix — Therapy and Complications," will be an analysis of approximately 1,000 cases of carcinoma of the cervix that have

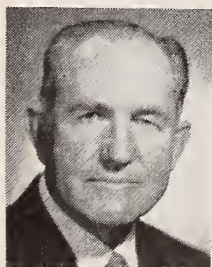
been treated at the Medical College of South Carolina. Irradiation therapy will be divided into conventional and supervoltage therapy with the advantages, disadvantages, and complications of supervoltage therapy discussed in some detail. Routine pre-therapy and post-therapy follow-up examinations and studies will be outlined and discussed. Lastly, our five year and ten year survival rates with irradiation therapy will be presented.

Dr. Hester's second paper, "Fetal Distress," is summarized below:

Fetal distress will be defined and methods discussed to determine this precarious intra-uterine condition. A small series of patients having pregnancies complicated by fetal distress will be discussed in detail in an effort to determine when surgical intervention is indicated. The immediate care of the infant with distress and anticipated distress will be emphasized.

Dr. Hester graduated from the Medical College of South Carolina and interned at Roper Hospital, Charleston. He was Assistant Resident in Obstetrics and Gynecology at the Roper Hospital, and a teaching fellow in Obstetrics and Gynecology at the Medical College of South Carolina. He is presently Professor and Chairman, Obstetrics and Gynecology, Medical College of South Carolina.

Dr. Hester has published many scientific papers. He is a member of the American Board of Obstetrics and Gynecology; a fellow of the American College of Obstetricians and Gynecologists, a fellow and Assistant Secretary-Treasurer of the South Atlantic Association of Obstetrics and Gynecology; a member of the Southeastern Obstetrical and Gynecological Society, the Southern Obstetrical and Gynecological Society, and is immediate past President of the South Carolina Obstetrics and Gynecology Society.



SAMUEL L. RAINES, M.D.
Memphis, Tennessee

DR. SAMUEL L. RAINES, Memphis, Tennessee, will present his first paper on Monday, May 6 at 10:30 A.M. Entitled, "Greetings from the American Urological Association," it will be read before the Obstetrics and Gynecology, Urology and Radiology Joint Section Meeting. His second paper will be given to the G. P. Day—General Session on Tuesday, May 7 at 10:30 A.M., and will concern, "Diagnosis and Treatment of Carcinoma of the Prostate

from A GP Viewpoint."

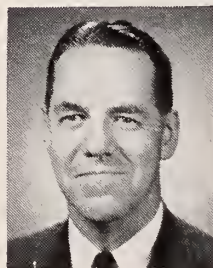
Graduated from the University of Tennessee College of Medicine, Dr. Raines is a Past-President of the Southeastern Section of the American Urological Association, Inc.; a Past-Secretary of the American Urological Association, Inc.; and President-Elect of the American Urological Association, Inc. He is currently Professor of Urology at the University of Tennessee College of Medicine, Memphis.

A summary follows of Dr. Raines' paper, "Diagnosis and Treatment of Carcinoma of the Prostate from A GP Viewpoint":

The general practitioner is the first and most important contact, or screening mechanism, in detecting early carcinoma of the prostate. All of us are concentrating our efforts on early diagnosis, rather than late diagnosis. Careful regular rectal examinations and a suspicious attitude toward nodules are required for early detection.

Once a nodule is felt and brought under suspicion, it is the doctor's responsibility to establish the diagnosis by a biopsy which may be done in several ways.

When carcinoma has been established, radical surgery is the best treatment when it is still possible. Palliation can help in the later inoperable types.



EDGAR A. HINES, JR., M.D.
Oteen, North Carolina

DR. EDGAR A. HINES, Consultant in Internal Medicine, Veterans Administration Hospital, Oteen, North Carolina, will present the Abner W. Calhoun Memorial Lectureship on Tuesday, May 7, at 12:00 NOON. Entitled, "Blood Pressure That is Too High or Too Low: Some Effects of Heredity, Gravity and Nerves," a short summation of the paper is given below:

The basic personality of many patients who eventually develop persistently high diastolic blood pressures may be described as that of a "non-procrastinating perfectionist." This may operate through an inherently hyperactive neurogenic mechanism affecting the baroreceptor or barostatic control in the carotid and aortic nerve centers or through changes in the higher (cerebral) controls in the frontal and temporal cortical areas of the brain. Much indirect evidence has been gained through extensive studies in the experimental animal and in the human (especially by well-qualified Russian investigators) that disturbances of cerebral cortical function can result in hypertension. This evidence and studies which have related an hereditary factor to neurogenic aspects

of the development of diastolic hypertension will be reviewed. The results of a follow-up study (after 27 years) of the blood pressures of 300 school children originally studied in 1934 will be given. The findings in this study lend support to the concept that transient increases in vasoconstriction through a neurogenic mechanism are an important antecedent to the development of persistent hypertension and that there is an hereditary factor associated with this trait.

South Carolina Graduate

Dr. Hines, a graduate of the Medical College of the State of South Carolina, interned at St. Elizabeth's Hospital, Richmond, Virginia, and was Chief Resident Physician, Spartanburg General Hospital, Spartanburg, South Carolina. He has been associated with the Mayo Clinic in several capacities, among them: Associate Profesosr of Medicine, Mayo Foun-

dation, Graduate School; Professor of Medicine, Mayo Foundation, Graduate School; and Head of Section of Medicine, Mayo Clinic. He has been Vice-president of Staff Mayo Clinic, Emeritus Consultant Mayo Clinic, and Emeritus Professor of Medicine, Graduate School, University of Minnesota. He entered his current position in 1962.

Memberships

Dr. Hines is a fellow of the American College of Physicians, a member of the American Society for Clinical Investigation, American Federation for Clinical Research; and Vice-Chairman, Section on Circulation, American Heart Association. In addition to co-authoring a textbook entitled, *Peripheral Vascular Diseases*, Dr. Hines is the author of approximately 160 papers on the various aspects of peripheral vascular diseases and blood pressure abnormalities.

1963 Annual Session Section Chairmen

ANESTHESIOLOGY

Bert H. Ellis, M.D.
3043 Sherwood Drive, Brunswick

CHEST

John A. Hightower, M.D.
2601 Parkwood Drive, Brunswick

DERMATOLOGY

Marvin F. Engel, M.D.
11 Professional Building, Brunswick

DIABETES

Haywood L. Moore, M.D.
2601 Parkwood Drive, Brunswick

GENERAL PRACTICE

Milledge Smith, M.D.
801 Mansfield Street, Brunswick

MEDICINE

Arthur M. Knight, Jr., M.D.
P.O. Box 899, Waycross

OBSTETRICS AND GYNECOLOGY

George B. Wheeler, III, M.D.
10 Professional Building, Brunswick

OPHTHALMOLOGY AND OTOLARYNGOLOGY

Braswell Collins, M.D.
740 Hemlock Street, Macon

ORTHOPEDICS

L. E. Dickey, M.D.
671 Hemlock Street, Macon

PATHOLOGY

Robert E. Perry, M.D.
Glynn-Brunswick Hospital, Brunswick

PEDIATRICS

Newell M. Hamilton, M.D.
2001 Gloucester Street, Brunswick

PSYCHIATRY

Sheldon B. Cohen, M.D.
Medical Arts Building, Atlanta 8

RADIOLOGY

Bert H. Malone, M.D.
1406 Reynolds Street, Brunswick

SURGERY

E. R. Jennings, M.D.
2601 Parkwood Drive, Brunswick

UROLOGY

Woodrow W. Payne, M.D.
Masonic Building, Brunswick

LAST CALL!

**Application for Space in the Scientific Exhibits of the
109TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA**

Aquarama, Jekyll Island, Georgia, May 5-8, 1963

For information and applications write to:

Edgar A. Grady, M.D., Chairman, MAG Scientific Exhibits Committee

938 Peachtree Street, N.E., Atlanta 9, Georgia

The Program

SATURDAY, MAY 4

Social Events

(Not a part of Official Program)

Saturday, May 4

NOTE: Make reservations in advance with Chairman if possible.

- 3:00 Georgia Chapter, American Academy of Pediatrics Annual Meeting and Business Meeting
To Be Announced
Howard J. Morrison, Savannah, Chairman
- 7:00 Georgia Society of Dermatologists Dinner
Benny's Red Barn, St. Simons Island
Marvin F. Engel, Brunswick, Chairman

SUNDAY MORNING, MAY 5

Social Events

(Not a part of Official Program)

Sunday Morning, May 5

NOTE: Make reservations in advance with Chairman if possible.

- 9:30 Georgia Society of Anesthesiologists Business Meeting
Stuckey's Carriage Inn
Bert H. Ellis, Brunswick, Chairman

SUNDAY NOON, MAY 5

Social Events

(Not a part of Official Program)

Sunday Noon, May 5

NOTE: Make reservations in advance with Chairman if possible.

- 11:30 Georgia Pediatric Society Luncheon
To Be Announced
Newell M. Hamilton, Brunswick, Chairman

SUNDAY AFTERNOON, MAY 5

2:00 MAG General Business Session

(ALL MAG AND AUXILIARY MEMBERS AND GUESTS INVITED)

Aquarama, Main Meeting Hall

PRESIDING

Thomas W. Goodwin, President

NOMINATION OF OFFICERS AND COUNCILORS
(*Announcement of Tellers Committee*)

President-Elect

Second Vice President

Secretary

Ninth District Councilor (To serve until 1966)

Ninth District Vice Councilor (To serve until 1966)

Tenth District Councilor (To serve until 1966)

Tenth District Vice Councilor (To serve until 1966)

Richmond County Medical Society Councilor (To serve until 1966)

Richmond County Medical Society Vice Councilor (To serve until 1966)

Bibb County Medical Society Councilor (To serve until 1966)

Bibb County Medical Society Vice Councilor (To serve until 1966)

Fulton County Medical Society Councilor (To serve until 1966)

Fulton County Medical Society Vice Councilor (To serve until 1966)

AMA Delegate (Term beginning January 1, 1964)

AMA Alternate Delegate (Term beginning January 1, 1964)

NOMINATIONS FOR AWARDS:

GENERAL PRACTITIONER OF THE YEAR AWARD

(To be voted on by the House of Delegates)

HARDMAN AWARD

2:30 Psychiatry, General Practice, Medicine, Dermatology, Diabetes and Chest Joint Section Meeting

(ALL PHYSICIANS INVITED)

Aquarama, Main Meeting Hall

PRESIDING

Marvin F. Engel, Brunswick

2:30 PRESENT DAY MANAGEMENT OF DIABETES
Priscilla White, Boston, Massachusetts

3:00 REGIONAL CANCER CHEMOTHERAPY
Elton Watkins, Jr., Boston, Massachusetts

3:30 BONE MARROW AUTOGRAFTS AND HOMOGRAFTS IN MAN
Alexander H. Woods, Oklahoma City, Oklahoma

4:00 METABOLIC ASPECTS OF PULMONARY DISEASE
Robert L. Mayock, Philadelphia, Pennsylvania

4:30 LUPUS ERYTHEMATOSUS
Lamar S. Osment, Birmingham, Alabama

2:30 Pediatrics and EENT Joint Section Meeting

(ALL PHYSICIANS INVITED)

Rooms 3 and 4, Stuckey's Carriage Inn

PRESIDING

R. K. Winston, Valdosta

- 2:30 PHENYLKETONURIA AS A CAUSE OF MENTAL DEFICIENCY—ITS MANAGEMENT WITH DIET

Oscar S. Spivey, Macon

- 2:45 SECRETORY OTITIS MEDIA

B. W. Armstrong, Charlotte, North Carolina

- 3:30 SIMPLIFIED APPROACH TO OTITIS EXTERNA

Ben H. Jenkins, Newnan

- 3:45 TUBERCULOSIS IN CHILDREN

Edwin L. Kendig, Jr., Richmond, Virginia

- 4:30 OPHTHALMOLOGICAL AIDS IN PEDIATRICS

F. Phinizy Calhoun, Jr., Atlanta

2:30 Anesthesiology and Orthopedics Joint Section Meeting

(ALL PHYSICIANS INVITED)

Ballroom, Stuckey's Carriage Inn

PRESIDING

Bert H. Ellis, Brunswick

- 2:30 THE MECHANICS OF ESTABLISHING AN OUT-PATIENT INHALATION THERAPY CLINIC

Lester Rumble, Jr., Atlanta

- 3:00 AN EVALUATION OF OPIATES FOR PAIN AND PREMEDICATION

John E. Steinhaus, Atlanta

PRESIDING

Walter P. Barnes, Jr., Macon

- 3:30 SALVAGING PROBLEM BACKS WITH INTER-BODY AND POSTERIOR ARTHRODESES

Austin T. Moore, Columbia, South Carolina

- 4:00 SUPRACONDYLAR FRACTURES OF THE HUMERUS IN CHILDREN

George S. Whatley, Columbus

- 4:15 PYOGENIC INFECTIONS IN BONES AND JOINTS

H. Benton Bridges, Augusta

- 4:30 DEFORMITIES ASSOCIATED WITH CLUBFEET

J. H. Kite, Atlanta

2:30 Radiology Section Meeting

(ALL PHYSICIANS INVITED)

Conference Room, Corsair Motel

PRESIDING

George W. Brown, Griffin

- 2:30 URINARY TRACT INFECTIONS IN INFANTS AND CHILDREN

John M. Dennis, Baltimore, Maryland

- 3:15 RADIOLOGIC EXAMINATION OF THE LARYNX

Harry H. McGee, Jr., Savannah

- 3:35 EXPERIENCES WITH MAMMOGRAPHY AT EMORY UNIVERSITY HOSPITAL

James V. Rogers and

R. Waldo Powell, Atlanta

3:55 FILM INTERPRETATION SESSION

MODERATOR

Harry H. McGee, Jr., Savannah

PANEL

(To be announced)

4:45 MAG Delegates Registration

Aquarama, Main Meeting Hall Entrance

5:00 House of Delegates Meeting

Aquarama, Main Meeting Hall

PRESIDING

J. Frank Walker, Atlanta,

Speaker of the House

- 5:05 ORDER OF BUSINESS (See Delegates Handbook)

REPORT OF PRESIDENT, WOMAN'S AUXILIARY TO MAG

Mrs. Ennis W. Waldemayer, Americus

- 5:45 "SOCIALIZED MEDICINE"

James W. Harkess, M.D., Augusta,

formerly of Edinburgh, Scotland

SUNDAY EVENING, MAY 5

6:30 House of Delegates and Exhibitors Social Hour

Buccaneer Motel

Social Events

(Not a part of Official Program)

Sunday Evening, May 5

NOTE: Make reservations in advance with Chairman if possible.

- 6:00 Georgia Industrial Medical Association Social Hour and Dinner
Mallard Room, Wanderer Motel

Claud S. Cobb, East Point, Chairman

- 6:00 Georgia Society of Internal Medicine Social Hour and Dinner
Sky Room, Wanderer Motel

Arthur M. Knight, Jr., Waycross, Chairman

- 7:00 Georgia Pediatric Society and Georgia Society of Ophthalmology and Otolaryngology Dinner
To Be Announced

Newell M. Hamilton, Brunswick and
Braswell Collins, Macon, Co-Chairmen

- 7:00 Georgia Orthopedic Society Dinner
Stuckey's Carriage Inn

L. E. Dickey, Brunswick, Chairman

- 7:00 Georgia Radiological Society Dinner
Beach Club, Cloister Hotel, Sea Island

Bert H. Malone, Brunswick, Chairman

MONDAY MORNING, MAY 6

8:00 MAG Reference Committees

- 8:00 REFERENCE COMMITTEE NO. 1
Rotunda, Aquarama

- 8:00 REFERENCE COMMITTEE NO. 2
Rotunda, Aquarama

- 8:00 REFERENCE COMMITTEE NO. 3
Rotunda, Aquarama

**9:00 Psychiatry, Medicine, Dermatology,
Diabetes and Chest Joint Section
Meeting**

(ALL PHYSICIANS INVITED)

Aquarama, Main Meeting Hall

PRESIDING

John A. Hightower, Brunswick

- 9:00 AGING SKIN
J. Graham Smith, Jr., Durham,
North Carolina
- 9:30 CHEMOPROPHYLAXIS OF TUBERCULOSIS
Robert L. Mayock, Philadelphia,
Pennsylvania
- 10:00 PREGNANCY DIABETES
Priscilla White, Boston, Massachusetts
- 10:30 REGIONAL CANCER CHEMOTHERAPY
Elton Watkins, Jr., Boston, Massachusetts
- 11:00 BIOLOGICAL DOSIMETRY
Alexander H. Woods, Oklahoma City,
Oklahoma
- 11:30 THE ROLE OF THE PHYSICIAN IN COMMU-
NITY MENTAL HEALTH
James Osberg, Silver Spring, Maryland

**9:00 Surgery, Orthopedics and
Anesthesiology Joint Section
Meeting**

(ALL PHYSICIANS INVITED)

Ballroom, Stuckey's Carriage Inn

PRESIDING

L. E. Dickey, Macon

- 9:00 ARTHROPLASTY OF HIP, USING MOORE
PROSTHESIS
Austin T. Moore, Columbia, South Carolina
- PRESIDING
E. R. Jennings, Brunswick
- 9:30 CHEMICAL AND METABOLIC CHANGES IN
THE TRAUMATIZED PATIENT
Robert W. Buxton, Baltimore, Maryland
- PRESIDING
Bert H. Ellis, Brunswick
- 10:00 PREANESTHETIC EVALUATION OF BLOOD
LOSS IN THE TRAUMATIZED PATIENT
Kenneth K. Keown, Columbia, Missouri
- 10:30 INTERMISSION
- 10:45 TRAUMA
- MODERATOR
E. R. Jennings, Brunswick
- PANEL
Austin T. Moore, Columbia, South Carolina
Robert W. Buxton, Baltimore, Maryland
Kenneth K. Keown, Columbia, Missouri

**9:00 Obstetrics and Gynecology, Urology
and Radiology Joint Section Meeting**

(ALL PHYSICIANS INVITED)

Rooms 3 and 4, Stuckey's Carriage Inn

PRESIDING

Woodrow W. Payne, Brunswick

- 9:00 CONTROL OF ABNORMAL PROSTATIC
BLEEDING
Albert Biggs, Memphis, Tennessee
- 9:30 CARCINOMA OF THE CERVIX — THERAPY
AND COMPLICATIONS
Lawrence L. Hester, Charleston,
South Carolina
- 10:00 RENOVASCULAR HYPERTENSION
John M. Dennis, Baltimore, Maryland
- 10:30 GREETINGS FROM THE AMERICAN
UROLOGICAL ASSOCIATION
Samuel L. Raines, Memphis, Tennessee
- 10:35 DISCUSSION
- MODERATOR
H. Stephen Weens, Atlanta
- PANEL
John M. Dennis, Baltimore, Maryland
Lawrence L. Hester, Charleston,
South Carolina
Albert Biggs, Memphis, Tennessee

9:00 Pathology Section Meeting

(ALL PHYSICIANS INVITED)

Sky Room, Wanderer Motel

PRESIDING

Leonard H. Campbell, Macon

- 9:00 MYXOMA OF THE HEART
Lynn Ogden, Augusta
- 9:30 CASE STUDY — UNCLASSIFIED TUMOR
Jack C. Norris, Atlanta
- 10:00 HISTOPATHOLOGICAL STUDIES OF
INTESTINAL BIOPSIES
H. J. Peters and
Victor A. Moore, Jr., Augusta
- 10:30 RADIOISOTOPE SCANNING OF BRAIN,
THYROID, LIVER AND KIDNEY
Menard Ihnen, Augusta
- 11:00 PROGRESSION OF THE RENAL LESION IN
LIPOID NEPHROSIS. CASES ILLUSTRATING
VARIATION IN CHILDHOOD AND ADULT
LIFE
Leland D. Stoddard and
Nancy Thornton, Augusta
- 11:30 PRIVATE PRACTICE OF PATHOLOGY IN
CLINICAL LABORATORY MEDICINE — THE
ROLE OF THE INDEPENDENT PATHOLOGIST
IN THE PROFESSIONAL COMMUNITY
Robert J. Peace, Atlanta

MONDAY AFTERNOON, MAY 6

12:00 MAG General Business Session

(ALL MAG AND AUXILIARY MEMBERS
AND GUESTS INVITED)

Aquarama, Main Meeting Hall

PRESIDING

Thomas W. Goodwin, Augusta, President,
Medical Association of Georgia

- 12:00 INVOCATION
Reverend Talbert Morgan, Rector,
St. Marks Episcopal Church, Brunswick
- 12:05 WELCOME
B. T. Galloway, Brunswick, President,
Glynn County Medical Society
- WELCOME
Honorable W. H. Sigman, Mayor,
City of Brunswick
- PRESIDING
Lee H. Battle, Rome, First Vice President
- REPORT OF THE PRESIDENTIAL YEAR
1962-63
Thomas W. Goodwin, Augusta, President
- OUR ASSOCIATION FUTURE FOR 1963-64
George R. Dillinger, Thomasville,
President-Elect

Social Events

(Not a part of Official Program)

Monday Afternoon, May 6

NOTE: Make reservations in advance with Chairman if possible.

- 12:00 Georgia Chapter, American College of Surgeons Luncheon
Stuckey's Carriage Inn
E. R. Jennings, Brunswick, Chairman
- 1:00 Georgia Chapter, American College of Chest Physicians and Georgia Thoracic Society Luncheon
Corsair Motel Restaurant
John A. Hightower, Brunswick, Chairman
- 1:00 Georgia Urological Society Luncheon
Aboard Ship
Woodrow W. Payne, Brunswick, Chairman
- 1:00 Georgia Radiological Society Luncheon and Business Meeting
Conference Room, Corsair Motel
Bert H. Malone, Brunswick, Chairman
- 1:00 Georgia Association of Pathologists Luncheon
Mallard Room, Wanderer Motel
Robert E. Perry, Brunswick, Chairman
- 1:00 Georgia Chapter, American Association Public Health Physicians Luncheon
To Be Announced
Ernest Thompson, Marietta, Chairman

2:30 MAG Reference Committees

- 2:30 REFERENCE COMMITTEE NO. 4
Rotunda, Aquarama
- 2:30 REFERENCE COMMITTEE NO. 5
Rotunda, Aquarama

MONDAY EVENING, MAY 6

Social Events

(Not a part of Official Program)

Monday Evening, May 6

NOTE: Make reservations in advance with Chairman if possible.

- 5:30 Georgia Society of Dermatologists Barbecue
South Picnic Area, Jekyll Island
Marvin F. Engel, Brunswick, Chairman
- 6:30 Medical College of Georgia Social Hour and Dinner
Gould Auditorium
Joseph B. Mercer, Brunswick, Chairman

TUESDAY MORNING, MAY 7

Social Events

(Not a part of Official Program)

Tuesday Morning, May 7

NOTE: Make reservations in advance with Chairman if possible.

- 7:30 Georgia Medical Political Action Committee Breakfast
(All Physicians Urged to Attend)
Banquet Room, Wanderer Motel Restaurant
Milford B. Hatcher, Macon, Chairman
- 7:45 Georgia Society of Clinical Hypnosis Breakfast
Stuckey's Carriage Inn
Sheldon B. Cohen, Atlanta, Chairman

9:00 G.P. Day—General Session

(ALL PHYSICIANS INVITED)

Aquarama, Main Meeting Hall

PRESIDING

Joseph B. Mercer, Brunswick

- 9:00 TOPICAL TREATMENT FOR SKIN DISEASES
Lamar S. Osment, Birmingham, Alabama

- 9:30 MANAGEMENT OF COMMON DERMATOLOGICAL PROBLEMS IN THE SOUTHERN UNITED STATES
J. Graham Smith, Jr., Durham, North Carolina

- 10:00 VERTIGO — DIFFERENTIAL DIAGNOSIS AND TREATMENT
B. W. Armstrong, Charlotte, North Carolina

- 10:30 DIAGNOSIS AND TREATMENT OF CARCINOMA OF THE PROSTATE FROM A G.P. VIEWPOINT
Samuel L. Raines, Memphis, Tennessee

- 11:00 NON-PENETRATING ABDOMINAL TRAUMA
Robert W. Buxton, Baltimore, Maryland

TUESDAY AFTERNOON, MAY 7

12:00 Abner W. Calhoun Memorial Lectureship

(ALL PHYSICIANS INVITED)

Aquarama, Main Meeting Hall

PRESIDING

Thomas W. Goodwin, Augusta

- 12:00 BLOOD PRESSURE THAT IS TOO HIGH OR TOO LOW: SOME EFFECTS OF HEREDITY, GRAVITY AND THE NERVES
Edgar A. Hines, Jr., Oteen, North Carolina

Social Events

(Not a part of Official Program)

Tuesday Afternoon, May 7

NOTE: Make reservations in advance with Chairman if possible.

- 1:00 Georgia Diabetes Society Luncheon
Corsair Motel Restaurant
Haywood L. Moore, Brunswick, Chairman
- 1:00 Georgia Academy of General Practice
Luncheon
Corsair Motel
Milledge G. Smith, Brunswick, Chairman
- 1:00 Georgia State Ob.-Gyn. Society Luncheon
To Be Announced
George B. Wheeler, Brunswick, Chairman

2:30 Surgery and Medicine Joint Section Meeting

(ALL PHYSICIANS INVITED)

Aquarama, Main Meeting Hall

PRESIDING

B. T. Galloway, Brunswick

- 2:30 TREATMENT OF FACIAL FRACTURES — A
SIMPLE AND EXACT TECHNIQUE
Carl R. Hartrampf, Atlanta
- 2:55 SURGICAL TREATMENT OF RENOVASCULAR
HYPERTENSION
Milton F. Bryant, Atlanta
- 3:20 SUPERIOR MESENTERIC ARTERY SYNDROME
Harold S. Engler, Thomas C. Mann and
William H. Moretz, Augusta
- 3:45 HYPOTHERMIA IN THE PRACTICE OF
GENERAL SURGERY
B. A. Addison and
E. R. Jennings, Brunswick
- 4:10 CANCER OF THE OVARY
Edgar D. Grady, Luther C. Rollins and
Walter T. Sale, Atlanta
- 4:30 SERIOUS TOXIC EFFECTS OF COMMONLY
USED DRUGS
D. F. Mullins, Augusta

2:30 Obstetrics and Gynecology Section Meeting

(ALL PHYSICIANS INVITED)

Ballroom, Stuckey's Carriage Inn

PRESIDING

Tom A. Dover, Athens

- 2:30 FETAL DISTRESS
Lawrence L. Hester, Charleston,
South Carolina
- 3:15 RUPTURE OF THE PREGNANT UTERUS,
WITH A REVIEW OF TWENTY CASES
Donald E. O'Rourke, Augusta
- INTERMISSION
- 3:40 AMENORRHEA OF PITUITARY ORIGIN
William C. Shirley, Macon
- 4:00 ORAL CONTRACEPTIVES IN IMMEDIATE
PUERPERIUM — A PRELIMINARY REPORT
Earnest M. Curtis, Atlanta

- 4:20 ECTOPIC PREGNANCY: A REVIEW OF 507
CASES

John C. Holley, Atlanta

- 4:45 DISCUSSION

MODERATOR

Tom A. Dover, Athens

PANEL

Lawrence L. Hester, Charleston,
South Carolina
Frederick P. Zuspan, Augusta
John R. Bottomy, Atlanta

WEDNESDAY MORNING, MAY 8

9:00 House of Delegates Second Meeting

Aquarama, Main Meeting Hall

PRESIDING

J. Frank Walker, Atlanta,
Speaker of the House

ORDER OF BUSINESS

(See Delegates Handbook)

11:00 MAG General Business Session

(ALL MAG AND AUXILIARY MEMBERS
AND GUESTS INVITED)

Aquarama, Main Meeting Hall

PRESIDING

Thomas W. Goodwin, Augusta, President

PRESENTATION OF 50 YEAR CERTIFICATES

Fred H. Simonton, Chickamauga, Immediate
Past President, Medical Association of
Georgia

PRESENTATION OF SCIENTIFIC EXHIBIT
AWARDS

Edgar Grady, Atlanta, Chairman,
Scientific Awards Committee

PRESENTATION OF GENERAL PRACTITIONER
OF THE YEAR AWARD

W. Frank McKemie, Albany, President,
Georgia Academy of General Practice

PRESENTATION OF MAG CERTIFICATES OF
APPRECIATION

John T. Mauldin, Atlanta, Secretary,
Medical Association of Georgia

PRESENTATION OF HARDMAN AWARD

George R. Dillinger, Thomasville,
President-Elect, Medical Association
of Georgia

PRESENTATION OF MAG DISTINGUISHED
SERVICE AWARD

Thomas W. Goodwin, Augusta, President,
Medical Association of Georgia

SELECTION OF SITE FOR ANNUAL MEETING
1965

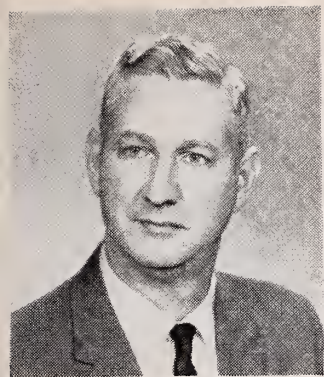
ANNOUNCEMENT OF MAG ELECTION
RESULTS

Chairman, Tellers Committee

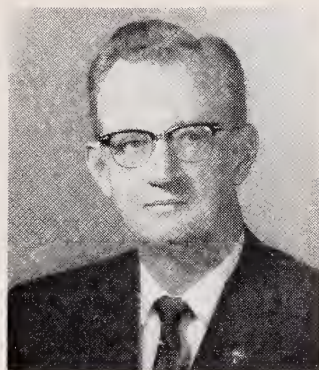
INSTALLATION OF 1963-1964 OFFICERS

Thomas W. Goodwin, Augusta, Immediate
Past President, Medical Association
of Georgia

ADJOURNMENT OF 109TH ANNUAL SESSION



LEE H. BATTLE
First Vice President

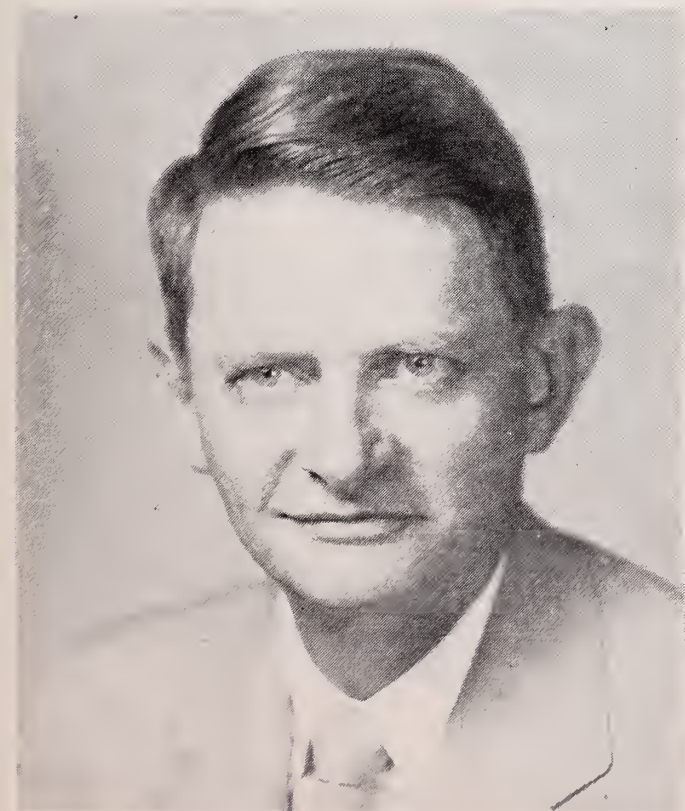


WALKER L. CURTIS
Second Vice President



THOMAS W. GOODWIN
President

MEDICAL ASSOCIATION OF GEORGIA OFFICERS 1962-1963



JOHN T. MAULDIN
Secretary



GEORGE R. DILLINGER
President-Elect

Medical Association of Georgia Officers, Committees and Board

Officers

President—Thomas W. Goodwin, Augusta (1963)*
President-Elect—George R. Dillinger, Thomasville (1963)*
Immediate Past President—Fred H. Simonton, Chickamauga (1963)*
First Vice President—Lee H. Battle, Rome (1963)*
Second Vice President—Walker L. Curtis, College Park (1963)
Chairman of Council—George H. Alexander, Forsyth (1963)*
Secretary—John T. Mauldin, Atlanta (1963)*
Treasurer—John S. Atwater, Atlanta (1963)*
Speaker of the House—J. Frank Walker, Atlanta (1965)
Vice Speaker of the House—Joseph B. Mercer, Brunswick (1965)
Editor, JMAG—Edgar Woody, Jr., Atlanta (1963)

* Executive Committee

Honorary Advisory Board

<i>Past Presidents</i>	<i>Term</i>
J. W. Palmer, Ailey	1918-1919
C. H. Richardson, Macon	1933-1934
Clarence L. Ayers, Toccoa . . .	1934-1935
Grady N. Coker, Canton	1938-1939
Allen H. Bunce, Atlanta	1941-1942
James A. Redfearn, Albany . . .	1942-1943
W. A. Selman, Atlanta	1943-1944
A. M. Phillips, Macon	1950-1951
W. F. Reavis, Waycross	1951-1952
C. F. Holton, Savannah	1952-1953
William P. Harbin, Jr., Rome . .	1953-1954
H. D. Allen, Jr., Milledgeville .	1955-1956
W. Bruce Schaefer, Toccoa . . .	1957-1958
Luther H. Wolff, Columbus . . .	1959-1960
Milford B. Hatcher, Macon . . .	1960-1961
Fred H. Simonton, Chickamauga .	1961-1962

Councilors

District
 1—Charles Bohler, Brooklet (1964)
 2—W. Frank McKemie, Albany (1964)
 3—Frank Wilson, Leslie (1964)
 4—Virgil Williams, Griffin (1964)
 5—Floyd Sanders, Decatur (1965)
 6—Wm. Rawlings, Sandersville (1965)
 7—Ralph N. Johnson, Rome (1965)
 8—F. G. Eldridge, Valdosta (1965)
 9—C. R. Andrews, Canton (1963)
 10—Addison Simpson, Jr., Washington (1963)
 Georgia Medical Society
 Walter Brown, Savannah (1964)
 Richmond County Medical Society
 H. D. Pinson, Augusta (1963)
 Muscogee County Medical Society
 W. P. Jordan, Columbus (1965)
 Bibb County Medical Society
 George Alexander, Forsyth (1963)
 Fulton County Medical Society
 J. C. McDaniel, Atlanta (1963)*

Vice Councilors

District
 1—William Simmons, Sylvania (1964)
 2—J. C. Brim, Pelham (1964)
 3—Robert Martin, Cuthbert (1964)
 4—C. T. Cowart, LaGrange (1964)
 5—Lawrence Matthews, Atlanta (1965)
 6—John Bell, Dublin (1965)
 7—W. C. Mitchell, Smyrna (1965)
 8—J. W. Yeomans, Jesup (1965)
 9—P. T. Scoggins, Commerce (1963)
 10—M. A. Hubert, Athens (1963)
 Georgia Medical Society
 T. A. Peterson, Savannah (1964)
 Richmond County Medical Society
 J. L. Mulherin, Augusta (1963)
 Muscogee County Medical Society
 Luther Wolff, Columbus (1965)
 Bibb County Medical Society
 W. H. M. Weaver, Macon (1963)
 Fulton County Medical Society
 Charles S. Jones, Atlanta (1963)

Delegates to the AMA

Delegate—J. W. Chambers, LaGrange (1964)
Alternate—George Dillinger, Thomasville (1964)
Delegate—Eustace A. Allen, Atlanta (1965)
Alternate—J. Frank Walker, Atlanta (1965)
Delegate—Henry H. Tift, Macon (1965)
Alternate—Preston D. Ellington, Augusta (1965)

ASSOCIATION COMMITTEES

Executive Committee

Thomas W. Goodwin, Augusta, *President* (1963)
 George R. Dillinger, Thomasville, *President-Elect* (1963)
 Fred H. Simonton, Chickamauga, *Immediate Past President* (1963)
 Lee H. Battle, Rome, *First Vice President* (1963)
 George H. Alexander, Forsyth, *Chairman of Council* (1963)
 John T. Mauldin, Atlanta, *Secretary* (1963)
 J. G. McDaniel, Atlanta, *Chairman of Finance* (1963)
 John S. Atwater, Atlanta, *Treasurer, Ex-officio* (1963)

Finance Committee

J. G. McDaniel, Atlanta, *Chairman*
 Virgil Williams, Griffin
 Charles R. Andrews, Canton

Professional Conduct Committee

H. D. Allen, Jr., Milledgeville, *Chairman*
 W. Bruce Schaefer, Toccoa
 Luther H. Wolff, Columbus
 Milford B. Hatcher, Macon
 Fred H. Simonton, Chickamauga
 Charles S. Jones, Atlanta

Woman's Auxiliary Advisory Committee

Ralph W. Fowler, Marietta, *Chairman*
 Remer Y. Clark, Marietta
 W. G. Elliott, Cuthbert
 E. W. Waldemayer, Americus
 Virgil B. Williams, Griffin, *Ex-officio*
 George R. Dillinger, Thomasville, *Ex-officio*
 T. A. Peterson, Savannah

ASSOCIATION BOARDS AND SUB-COMMITTEES

Board of Annual Session

Peter Hydrick, College Park, *Chairman* (1964)
 Braswell Collins, Macon, *Vice Chairman* (1963)
 Thomas W. Goodwin, Augusta (1964)
 Luther H. Wolff, Columbus (1965)
 M. Freeman Simmons, Decatur (1963)

Board of Constitution and Bylaws

W. G. Elliott, Cuthbert, *Chairman* (1964)
 J. L. Mulherin, Augusta, *Vice Chairman* (1964)
 Virgil Williams, Griffin (1963)
 Alex Jones, Griffin (1965)
 Lee H. Battle, Rome (1963)

Board of Governmental

Medical Services

Luther H. Wolff, Columbus, *Chairman* (1964)
 W. Bruce Schaefer, Toccoa, *Vice Chairman* (1964)
 A. W. Simpson, Washington (1963)
 Eugene Griffin, Atlanta (1965)
 Virgil B. Williams, Griffin (1965)
 F. J. Funk, Atlanta (1965)
 R. D. Edenfield, Macon (1963)
 Ernest B. Dunlap, Atlanta (1965)
 John Bowen, Sandy Springs (1963)
Sub-Committee on Crippled Children
 Ernest B. Dunlap, Jr., Atlanta, *Chairman*
 J. C. Hughston, Columbus
 F. James Funk, Jr., Atlanta
 John L. Chandler, Jr., Augusta
 H. M. Coe, Brunswick
 Robert Mabon, Atlanta

James W. Bennett, Augusta
 W. G. Elliott, Cuthbert
 Ruth M. Waring, Savannah
 Atwood M. Freeman, Jr., Albany
 Walter P. Barnes, Jr., Macon

Sub-Committee on Disaster Medical Care

Virgil Williams, Griffin, *Chairman*
 Charles E. Dowman, Atlanta, *Vice Chairman*
 W. Harrison Reeves, Atlanta
 P. P. Volpito, Augusta
 W. D. Hazelhurst, Macon
 James W. Harkess, Augusta
 T. J. Ferrell, Waycross
 George M. Hutto, Columbus
 J. L. Elliott, Savannah
 Clarence J. Sapp, Rome
 Lester Petrie, Atlanta, *Ex-officio*
 Mrs. Kells Boland, Atlanta, *Ex-officio*
 Burch Robert, Macon, *Ex-officio*
 Paul T. Ericson, Atlanta, *Ex-officio*
 O. F. Whitman, Atlanta, *Ex-officio*
 Charles B. Brown, Atlanta, *Ex-officio*

Sub-Committee on Maternal and Infant Welfare

Eugene L. Griffin, Atlanta, *Chairman*
 Helen W. Bellhouse, Atlanta, *Vice Chairman*

Maternal Group

Eugene L. Griffin, Atlanta, *Chairman*
 Helen W. Bellhouse, Atlanta
 H. J. Bickerstaff, Columbus
 Peter Hydrick, College Park
 J. W. Smith, Manchester
 A. G. LeRoy, Thomson
 C. I. Bryans, Augusta
 Luella M. Klein, Atlanta
 F. P. Zusan, Augusta, *Ex-officio*
 John D. Thompson, Decatur, *Ex-officio*

Perinatal Group

Wm. E. Laupus, Augusta, *Chairman*
 Eugene L. Griffin, Atlanta
 Helen W. Bellhouse, Atlanta
 James W. Bennett, Augusta
 John P. Jones, Macon
 J. H. Patterson, Atlanta
 John D. Thompson, Decatur
 Lillian Warnick, Atlanta

Sub-Committee on Public Health

R. W. Edenfield, Macon, *Chairman*
 Alex G. Little, Valdosta
 Lee H. Battle, Jr., Rome
 J. Miller Byne, Waynesboro
 Virgil B. Williams, Griffin
 Samuel U. Braly, Dallas

Sub-Committee on Rehabilitation

F. J. Funk, Atlanta, *Chairman*
 John B. O'Neal, Elberton
 Vernon E. Powell, Atlanta
 W. Upton Clary, Savannah
 Mercer Blanchard, Columbus
 Thomas P. Goodwyn, Atlanta
 Robert L. Bennett, Warm Springs

Sub-Committee on School Child Health

John Bowen, Sandy Springs, *Chairman*
 J. C. Hughston, Columbus
 William H. Bonner, Athens
 Virginia McNamara, Atlanta

Sub-Committee on Veterans Affairs

W. Bruce Schaefer, Toccoa, *Chairman*
 Lee Howard, Jr., Savannah
 F. P. Holder, Eastman

Board of Hospital Activities

Milford B. Hatcher, Macon, *Chairman* (1965)
 Walter E. Brown, Savannah, *Vice Chairman* (1964)
 Rafe Banks, Jr., Gainesville (1963)
 Jack C. Norris, Atlanta (1965)
 Ralph N. Johnson, Rome (1964)
Sub-Committee on Blood Banks
 Jack C. Norris, Atlanta, *Chairman*
 Irving Greenberg, Atlanta
 Walter Sheppard, Augusta
Sub-Committee on Hospital Relations
 Milford B. Hatcher, Macon, *Chairman*
 W. L. Pomeroy, Waycross
 Rafe Banks, Gainesville
 C. W. Mills, Jr., Atlanta
 P. W. Waga, Athens

Sub-Committee on AMA-ERF

Braswell E. Collins, Macon, *Chairman*
 J. W. Williams, Augusta
 C. B. Elliott, Cedartown
 Edgar Boling, Atlanta
 Mrs. W. P. Stoner, Sylvester (Auxiliary)

Sub-Committee on Clarksville Labs.

Ben K. Looper, Canton, *Chairman*
 Sam Talmadge, Athens
 Hamil Murray, Gainesville
 Lee Howard, Jr., Savannah

Sub-Committee on Medical Education

Walter Bloom, Marietta, *Chairman*
 James C. Metts, Savannah
 J. Willis Hurst, Atlanta

Harry B. O'Rear, Augusta, *Ex-officio*

A. P. Richardson, Atlanta, *Ex-officio*

Sub-Committee on Medical School Course

T. A. Sappington, Thomaston, *Chairman*
 Robert Major, Augusta
 Linton H. Bishop, Atlanta

Board of Insurance and Economics

David R. Thomas, Jr., Augusta, *Chairman*
 (1964)

W. L. Pomeroy, Waycross, *Vice Chairman*
 (1964)

H. D. Pinson, Augusta (1963)

A. M. Phillips, Macon (1963)

William Moore, Atlanta (1965)

Sub-Committee on Relative Value Study

Harry D. Pinson, Augusta, *Chairman*
 Robert E. Cato, Macon
 Remer Y. Clark, Marietta
 Joseph E. Griffith, Marietta
 David R. Thomas, Augusta

Board of Interprofessional Relations

J. G. McDaniel, Atlanta, *Chairman* (1964)
 Henry Finch, Atlanta, *Vice Chairman* (1964)
 W. Frank McKemie, Albany (1963)
 William Coles, Atlanta (1965)
 Samuel U. Braly, Dallas (1963)

Board of Legislation

Samuel U. Braly, Dallas, *Chairman* (1964)
 John Bell, Dublin, *Vice Chairman* (1964)
 J. Frank Walker, Atlanta (1964)
 W. J. Williams, Augusta (1963)
 Fred L. Allman, Atlanta (1965)
 Maurice Arnold, Hawkinsville (1965)
 Thomas Gilmore, Sandersville (1963)
 William Harbin, Rome (1965)

Sub-Committee on National Legislation

J. Frank Walker, Atlanta, *Chairman*
 1st District—T. A. Peterson, Savannah
 2nd District—W. Frank McKemie, Albany
 3rd District—Robert Pendergrass, Americus
 4th District—J. W. Chambers, LaGrange
 5th District—Thomas Florence, Atlanta
 6th District—John Bell, Dublin

7th District—Fred H. Simonton, Chickamauga

8th District—Horace Joiner, Douglas

9th District—C. J. Roper, Jasper

10th District—R. H. Randolph, Athens

Sub-Committee on State Legislation

John Bell, Dublin, *Chairman*
 Thomas Florence, Atlanta
 Frank P. Holder, Eastman
 Albert Deal, Statesboro
 Robert Quattlebaum, Valdosta
 Braswell Collins, Macon
 P. K. Dixon, Gainesville
 A. W. Simpson, Jr., Washington
 Jack Austin, Griffin

Board of Medical Education

T. A. Sappington, Thomaston, *Chairman*
 (1964)

J. W. Chambers, LaGrange, *Vice Chairman*
 (1964)

Corbett Thigpen, Augusta (1963)

Walter Bloom, Marietta (1965)

Braswell Collins, Macon (1965)

W. H. M. Weaver, Macon (1963)

Ben K. Looper, Canton (1965)

Board of Occupational Health

T. A. Peterson, Savannah, *Chairman* (1964)

C. L. Ridley, Jr., Macon, *Vice Chairman*
 (1964)

C. R. Andrews, Canton (1963)

Thomas N. Lumsden, Clarkesville (1963)

Joseph E. Griffith, Marietta (1963)

Sub-Committee on Industrial Health

C. L. Ridley, Jr., Macon, *Chairman*

T. A. Peterson, Savannah

L. H. Griffin, Claxton

Allen M. Collinsworth, Atlanta

Sub-Committee on Rural Health

Thomas N. Lumsden, Clarkesville, *Chairman*

Carl S. Pittman, Jr., Tifton

J. S. Garner, Rome

R. D. Walter, Calhoun

Board of Public Service

Linton H. Bishop, Atlanta, *Chairman* (1964)

Floyd Sanders, Decatur, *Vice Chairman*
 (1964)

M. A. Hubert, Athens (1965)

J. Rhodes Haverty, Atlanta (1963)

Joseph B. Mercer, Brunswick (1963)

Sub-Committee on Public Service

Floyd B. Sanders, Decatur, *Chairman*

William C. Coles, Atlanta

Thomas N. Lumsden, Clarkesville

Darius Flinchum, Atlanta

Public Service Information**Cleaning House Sub-Committee**

W. D. Stribling, Gainesville
 John Yauger, Atlanta
 Fincher Powell, Decatur

Sub-Committee on Weekly Health Column

J. Rhodes Haverty, Atlanta, *Chairman*

J. Bothwell Traylor, Athens

Hamil Murray, Gainesville

J. Harry Rogers, Atlanta

James Smith, Rome

E. P. Inglis, Marietta

Nathan Gershon, Atlanta

C. B. Fulghum, Jr., Atlanta

A. C. Johnson, Jr., Gainesville

Crawford Long, Atlanta

James F. Olley, Atlanta

Jack Birge, Carrollton

Frederick F. Hardin, Atlanta

Stuart Fitzhugh, Griffin

G. R. Foster, McDonough

F. James Funk, Atlanta

Charles E. Dowman, Atlanta

Robert C. Shuman, Marietta

Harrison L. Rogers, Atlanta

Board of Special Activities

John S. Atwater, Atlanta, *Chairman* (1964)

Frank A. Wilson, Jr., Leslie, *Vice Chairman*
 (1964)

C. T. Cowart, LaGrange (1965)

Leo Smith, Waycross (1963)

Hoke Wammock, Augusta (1963)

C. L. Edwards, Dalton (1965)

Sub-Committee on Health Care of Aging

John S. Atwater, Atlanta, *Chairman*

John T. Mauldin, Atlanta

John L. Elliott, Savannah

Board of Volunteer Health Agencies

R. C. Pendergrass, Americus, *Chairman*
 (1964)

P. T. Scoggins, Commerce, *Vice Chairman*
 (1964)

James N. Brawner, Atlanta (1963)

F. G. Eldridge, Valdosta (1963)

Thomas L. Ross, Macon (1965)

Sub-Committee on Cancer

R. C. Pendergrass, Americus, *Chairman*

Ralph J. Davis, Rome

John T. Mauldin, Atlanta

Everett L. Bishop, Atlanta

Thomas Harrold, Macon

Hoke Wammock, Augusta

Robert L. Brown, Atlanta

John T. Godwin, Atlanta

H. H. McGee, Jr., Savannah

Sub-Committee on Mental Health

1st District—Abraham Center, Savannah

2nd District—W. V. Watt, Thomasville

3rd District—Frank A. Wilson, Leslie

4th District—Herbert D. Tyler, Thomaston

5th District—James N. Brawner, Atlanta,
Chairman

6th District—J. R. S. Mays, Macon

7th District—M. V. B. Teem, Marietta

8th District—Leo Smith, Waycross

9th District—P. K. Dixon, Gainesville

10th District—B. F. Moss, Augusta

Addison M. Duval, Atlanta, *Ex-officio*

VOTING RULES

Bylaws, Chapter V, Election of Officers

SECTION 3. METHOD. The President shall appoint a committee of not less than three Tellers immediately after the close of nominations, who shall have charge of the election. The Secretary shall have prepared in advance an official ballot and an official ballot box, which shall be kept in the custody of the Tellers Committee. One ballot only shall be given to each active voting member when he presents himself to cast his ballot. Each member and no other shall prepare his ballot and shall deposit it at that time in the locked ballot box.

The candidates for office receiving a majority of the votes shall be declared elected, but if no majority is received on the first ballot, the members present shall select by secret ballot the officer from the two candidates having the highest number of votes.

SECTION 4. TIME. Voting shall take place during the hours of the scientific program up to the beginning of the last meeting on the last day of the Annual Session. At that time the Committee of Tellers shall count the ballots and report their findings to the members.

District Society Officers

First District

R. B. Gottschalk, Savannah, *President*
V. J. Cirincione, Savannah, *Secretary*

Second District

James H. Crowdis, Blakely, *President*
Julian B. Neel, 207 E. Jackson Street,
Thomasville, *Secretary*

Third District

Maurice Arnold, Hawkinsville, *President*
Robert Collins, 142 S. Jackson Street,
Americus, *Secretary*

Fourth District

Norman Gardner, Thomaston, *President*
Morgan Kellum, Thomaston, *Secretary*

Fifth District

J. Frank Walker, 1293 Peachtree Street, N.E.,
Atlanta 9, *President*
Carl C. Jones, 1293 Peachtree Street, N.E.,
Atlanta 9, *Secretary*

Sixth District

J. P. Woodhall, 724 Hemlock Street, Macon,
President
Hugh K. Sealy, 765 Spring Street, Macon,
Secretary

Seventh District

Remer Y. Clark, 1422 Cherokee Street,
Marietta, *President*

Eighth District

Duncan Farris, 202½ Folks Street, Waycross,
President
Neal F. Yeomans, Waycross, *Secretary*

Ninth District

Rupert Bramblett, Cumming, *President*
Hamil Murray, Gainesville, *Secretary*

Tenth District

James A. Green, 1010 Prince Avenue,
Athens, *President*
C. E. Wills, Jr., Washington, *Secretary*

Specialty Society Officers

Georgia Heart Association

William B. Fackler, Jr., LaGrange, *President*
Henry S. Jennings, Jr., Gainesville, *Secretary*
Mr. Linwood Beck, 58 Baltimore Place,
N.W., Atlanta 8, *Executive Secretary*

Georgia Pediatric Society

Joseph H. Patterson, 1405 Clifton Road,
N.E., Atlanta 22, *President*
L. C. Antrobus, 3139 Maple Drive, N.E.,
Atlanta 5, *Secretary*

Georgia Society of Ophthalmology and Otolaryngology

T. S. Burgess, Strickler Building., Atlanta,
President
James T. King, 340 Boulevard, N.E.,
Atlanta 12, *Secretary*

Georgia Association of Pathologists

L. H. Campbell, 548 First Street, Macon,
President
John T. Godwin, 265 Ivy Street, N.E.,
Atlanta 3, *Secretary*

Georgia Society of Anesthesiologists

Bert H. Ellis, 3043 Sherwood Drive,
Brunswick, *President*
Frederick A. Carpenter, 89 Butler Street,
S.E., Atlanta 3, *Secretary*

Georgia State OB and GYN Society

Tom A. Dover, 1010 Prince Avenue, Athens,
President
B. A. McCrum, 420 E. Broad Street,
Gainesville, *Secretary*

Georgia Orthopedic Society

Fred E. Murphy, Jr., Thomasville, *President*
Richard E. King, 340 Boulevard, N.E.,
Atlanta 12, *Secretary*

Georgia Chapter, American College of Surgeons

Lee H. Battle, 321 W. 7th Street, Rome,
President
S. A. Roddenbery, 711 Center Street,
Columbus, *Secretary*

Georgia Radiological Society

George W. Brown, Griffin, *President*
David Robinson, 9 Medical Arts Center,
Savannah, *Secretary*

Georgia Chapter, American College of Chest Physicians

Harry H. McGee, 7 Gordon Street,
Savannah, *President*
Robert Vaughan, Columbus, *Secretary*

Georgia Urological Association

W. H. Bennett, 340 Boulevard, N.E.,
Atlanta, *President*
David C. Williams, Jr., 1142 Druid Park
Avenue, Augusta, *Secretary*

Georgia Diabetes Association

Jules Victor, Jr., Savannah, *President*
Lawrence Lee, Jr., Savannah, *Secretary*

Georgia Thoracic Society

James L. Alexander, 104 E. Gwinnett Street,
Savannah, *President*
Coleman T. King, Battey State Hospital,
Rome, *Secretary*
Mr. Carl Fox, 5 Forsyth Street, N.W.,
3rd Floor, Atlanta, *Executive Secretary*

Georgia Psychiatric Association

Sidney O. Isenberg, 101 Third Street, N.E.,
Atlanta, *President*
Sheldon B. Cohen, Medical Arts Building,
Atlanta 8, *Secretary*

Georgia Society of Dermatologists

Marvin F. Engel, 2001 Gloucester Street,
Brunswick, *President*
R. M. Reifler, 729 Pine Street, Macon,
Secretary

Georgia Academy of General Practitioners

W. Frank McKemie, 108 N. Monroe Street,
Albany, *President*
M. Freeman Simmons, 380 W. Ponce de
Leon Avenue, Decatur, *Secretary*

Georgia Society of Internal Medicine

Edward L. Bosworth, Harbin Clinic, Rome,
President
J. S. Wilson, 490 Peachtree Street, N.E.,
Atlanta 8, *Secretary*

American College of Physicians

Sterling Claiborne, 384 Peachtree Street,
N.E., Atlanta 8, *President*

County Society Officers

1—ALTAMAHA—1963

I. A. Bedingfield, Baxley, President
Dan B. Elrod, Hazlehurst, Secretary

2—BALDWIN—1963

J. G. Bohorfoush, Milledgeville, President
George L. Echols, Jr., Milledgeville, Secretary

4—BARTOW—1963

L. R. Whatley, Cartersville, President
Virginia D. Hamilton, Cartersville, Secretary

5—BEN HILL-IRWIN—1963

George Mixon, Ocilla, President
Ralph D. Roberts, Fitzgerald, Secretary

6—BIBB—1963

E. C. McMillan, Jr., Macon, President
John T. DuPree, Macon, Secretary

7—BLUE RIDGE—1962

H. E. Mitzelfelt, Ellijay, President
Thomas J. Hicks, McCaysville, Secretary

8—BULLOCH-CANDLER-EVANS—1963

S. P. Tillman, Statesboro, President
R. S. Robinson, Metter, Secretary

9—BURKE—1963

J. M. Byne, Jr., Waynesboro, President
Charles G. Green, Waynesboro, Secretary

10—CARROLL-DOUGLAS-HARALSON—1963

R. D. Allen, Tallapoosa, President
J. H. Beall, Carrollton, Secretary

11—GEORGIA MEDICAL SOCIETY—1963

Charles L. Prince, Savannah, President
J. J. Holloman, Savannah, Secretary

12—CHATTOOGA—1963

Hugh Goodwin, Summerville, President
J. A. Stewart, Summerville, Secretary

13—CHATTAHOOCHEE—1963

Sylvester Cain, Norcross, President
Cecil L. Miller, Buford, Secretary

14—CHEROKEE-PICKENS—1962

Arthur M. Hendrix, Canton, President
John A. Cauble, Canton, Secretary

15—CRAWFORD W. LONG—1962

John M. Wilkins, Athens, President
George Erwin, Athens, Secretary

16—CLAYTON-FAYETTE—1962

T. J. Busey, Fayetteville, President
Wells Riley, Jonesboro, Secretary

17—COBB—1963

Noah D. Meadows, Marietta, President
Robert D. Mainor, Smyrna, Secretary

18—COFFEE—1962

Dan A. Jardine, Douglas, President
C. S. Meeks, Jr., Douglas, Secretary

19—COLQUITT—1963

John P. Tucker, Moultrie, President
Walter E. Harrison, Moultrie, Secretary

20—COWETA—1963

Ernest E. Proctor, Newnan, President
Robert P. Taylor, Grantville, Secretary

21—DECATUR-SEMINOLE—1963

Charles C. Stewart, Donalsonville, President
M. A. Ehrlich, Bainbridge, Secretary

22—DEKALB—1963

Robert I. Gibbs, Decatur, President
M. Hobson Rice, Decatur, Secretary

23—DOUGHERTY—1963

T. D. Johnson, Albany, President
A. O. Goldsmith, Albany, Secretary

24—CAMDEN-CHARLTON—1963

R. R. McCollum, Kingsland, President
H. H. Robinson, Kingsland, Secretary

25—EMANUEL—1963

R. J. Moye, Swainsboro, President
H. R. Frost, Swainsboro, Secretary

26—FLINT—1963

J. T. Christmas, Vienna, President.
W. Kelvin Lane, Ashburn, Secretary

27—FLOYD—1963

C. J. Wyatt, Rome, President
Cliff Moore, Rome, Secretary

28—FRANKLIN-HART-ELBERT—1963

L. G. Cacchioli, Hartwell, President
C. A. Mickel, Jr., Elberton, Secretary

29—FULTON—1963

R. C. Davis, Atlanta, President
Thomas J. Anderson, Atlanta, Secretary

30—GLYNN—1963

B. T. Galloway, Brunswick, President
J. L. Owens, Jr., Brunswick, Secretary

31—GORDON—1963

W. R. Thompson, Calhoun, President
J. LeRoy Rabb, Calhoun, Secretary

32—GRADY—1962

John Ferrence, Whigham, President
C. K. Singleton, Cairo, Secretary

33—HABERSHAM—1963

W. T. Ariail, Cornelia, President
Jack B. Edwards, Jr., Cornelia, Secretary

34—HALL—1963

P. K. Dixon, Gainesville, President
Clark Ferrell, Gainesville, Secretary

36—PEACH BELT—1963

H. E. Weems, Jr., Perry, President
J. R. Arnall, Perry, Secretary

37—JACKSON-BARROW—1963

Joe Griffith, Commerce, President
A. A. Rogers, Jr., Commerce, Secretary

38—JASPER—1963

Ben C. Barrow, Monticello, President
E. M. Lancaster, Shady Dale, Secretary

39—JEFFERSON—1963

C. Roy Williams, Wadley, President
John Pilcher, Wrens, Secretary

40—JENKINS—1963

W. W. Hillis, Jr., Millen, President
A. P. Mulkey, Millen, Secretary

41—LAMAR—1962

J. H. Jackson, Barnesville, President
S. B. Taylor, Barnesville, Secretary

42—LAURENS—1963

Fred P. Chambless, Dublin, President
Nelson Carswell, Dublin, Secretary

44—McDUFFIE—1963

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John W. Lemley, Thomson, Secretary

45—MERIWETHER-HARRIS—1963

Jack W. Whitworth, Greenville, President
H. Calvin Jackson, Manchester, Secretary

46—MITCHELL—1963

M. W. Williams, Camilla, President
A. A. McNeill, Jr., Camilla, Secretary

47—MUSCOGEE—1963

Roy L. Gibson, Columbus, President
C. D. Johnson, Columbus, Secretary

48—NEWTON-ROCKDALE—1962

Robert Martin, Conyers, President
T. L. Crews, Covington, Secretary

49—OCONEE VALLEY—1962

C. H. Dickens, Madison, President
L. K. Lewis, Madison, Secretary

50—OCMULGEE—1963

W. F. Durham, Abbeville, President
Blake Bivins, Cochran, Secretary

51—POLK—1963

Harold W. Goldin, Rockmart, President
A. B. Campbell, Cedartown, Secretary

52—RABUN—1962

J. C. Dover, Clayton, President
John T. Norman, Clayton, Secretary

53—RANDOLPH TERRELL—1963

Earl Mayo, Richland, President
Carl E. Sills, Cuthbert, Secretary

54—RICHMOND—1963

Preston D. Ellington, Augusta, President
Henry D. Scoggins, Augusta, Secretary

55—SCREVEN—1962

G. B. Hogsette, Sylvania, President
J. C. Freeman, Sylvania, Secretary

56—SOUTH GEORGIA—1963

John M. Miller, Valdosta, President
B. S. Davis, Valdosta, Secretary

57—SOUTHEAST GEORGIA—1963

Robert W. Oliver, Lyons, President
Michael H. Whittle, Lyons, Secretary

58—SOUTHWEST GEORGIA—1963

H. L. Lassiter, Arlington, President
R. E. Jennings, Arlington, Secretary

59—SPALDING—1963

Grady Black, Griffin, President
T. L. Lipscomb, Griffin, Secretary

60—STEPHENS—1963

Robert E. Thompson, Toccoa, President
Irving D. Hellenga, Toccoa, Secretary

61—SUMTER—1963

W. R. Anderson, Americus, President
H. L. Simpson, Americus, Secretary

63—TAYLOR—1962

F. H. Sams, Reynolds, President
E. C. Whatley, Reynolds, Secretary

64—TELFAIR—1963

F. R. Mann, Jr., McRae, President
D. B. McRae, McRae, Secretary

65—THOMAS-BROOKS—1963

H. C. Courson, Thomasville, President
J. B. Neel, Thomasville, Secretary

66—TIFT—1963

W. L. Bridges, Tifton, President
C. S. Pittman, Sr., Tifton, Secretary

67—TRI COUNTY

68—TROUP—1963

B. H. Hand, LaGrange, President
J. F. Krafka, LaGrange, Secretary

69—UPSON—1963

D. L. Head, Thomaston, President
W. P. Woodall, Thomaston, Secretary

70—WALKER-CATOOSA-DADE—1963

Leroy Sherill, Rossville, President
M. K. Cureton, Lafayette, Secretary

71—WALTON—1963

J. F. Brooks, Monroe, President
R. E. Wenzel, Monroe, Secretary

72—WARE—1963

L. C. Durrence, Blackshear, President
S. W. Clark, Jr., Waycross, Secretary

73—WARREN—1962

H. B. Cason, Warrenton, President

74—WASHINGTON—1963

T. W. Gilmore, Sandersville, President
L. R. Harvey, Sandersville, Secretary

75—WAYNE—1963

R. A. Pumpelly, Jesup, President
D. H. G. Glover, Jesup, Secretary

76—WHITFIELD—1963

James A. Redfearn, Dalton, President
Fort F. Felker, Dalton, Secretary

78—WILKES—1962

A. D. Duggan, Washington, President
Henry C. Standard, Jr., Washington, Secretary

79—WORTH—1962

J. L. Tracy, Sylvester, President
H. G. Davis, Jr., Sylvester, Secretary

Woman's Auxiliary to the Medical Association of Georgia

38th Annual Meeting

May 5-8, 1963 — Jekyll Island, Georgia

President's Invitation

Welcome to Jekyll Island for the 38th Annual Meeting of the Woman's Auxiliary to the Medical Association of Georgia, May 5-8, 1963.

The beauty and restfulness of Jekyll—the Gem of the Golden Isles—awaits you. The Auxiliary to the Glynn County Medical Society is eagerly and wholeheartedly planning an exciting agenda. This is a “first” Annual Meeting at Jekyll and it promises to be a *memorable* occasion. Make your reservations today! Be among those who can reminisce in years to come . . .

“Remember in May '63

We meet at Jekyll by the sea.”

Anticipating seeing you,

Mrs. Ennis W. Waldemayer

President

Woman's Auxiliary to the

Medical Association of Georgia



MRS. ENNIS W. WALDEMAYER



MRS. WILLIAM O. INMAN, JR.

Welcome to Georgia's Golden Isles!

The Glynn County Medical Auxiliary is honored to be your hostess for the annual meeting. We plan to entertain you in a way you will long remember with pleasure.

You will love historic Jekyll Island with the many recreational facilities available for your enjoyment.

Mrs. William O. Inman, Jr.

President, Woman's Auxiliary

of the Glynn County Medical Society

ORGANIZATION of the Woman's Auxiliary to the Medical Association of Georgia

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President—Mrs. Ennis W. Waldemayer.....Americus
 President-Elect—Mrs. John E. Porter.....Savannah
 First Vice-President—Mrs. Louie H. Griffin.....Claxton
 Second Vice-President—Mrs. L. G. Cacchioli.....Hartwell
 Third Vice-President—Mrs. W. Holloway Bush.....Macon
 Corresponding Secretary—Mrs. Herschel A. Smith.....Americus
 Recording Secretary—Mrs. W. William Clark.....Waycross
 Treasurer—Mrs. John T. Godwin.....Atlanta
 Historian—Mrs. James M. Skinner.....Griffin
 Parliamentarian—Mrs. Leo Smith.....Waycross

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 Thomas W. Goodwin, M.D., *Ex-officio*.....Augusta
 George R. Dillinger, M.D., *Ex-officio*.....Thomasville
 Remer Y. Clark, M.D.....Marietta
 W. G. Elliott, M.D.....Cuthbert
 T. A. Peterson, M.D.....Savannah
 Virgil B. Williams, M.D.....Griffin
 Ennis W. Waldemayer, M.D.....Americus

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Achievement Award—Mrs. Floyd R. Sanders.....Decatur
 American Medical Association
 Education and Research Foundation—Mrs. W. P. Stoner.....Sylvester
 Archives—Mrs. Edward L. Askren, Jr.....Atlanta
 Auxiliary Headquarters Room—Mrs. Remer Y. Clark.....Marietta
 Brawner Trophy—Mrs. A. Worth Hobby.....Atlanta
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 Bulletin—Mrs. Carl S. Pittman, Jr.....Tifton
 Bylaws and Procedure—Mrs. C. James Roper.....Jasper
 Civil Defense—Mrs. F. Kels Boland, Jr.....Atlanta
 Community Service—Mrs. L. G. Cacchioli.....Hartwell
 Doctors' Day—Mrs. Carl P. Savage, Sr.....Montezuma
 Editorial—Mrs. James H. Manning.....Marietta
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 International Health Activities—Mrs. W. P. Rhyne.....Albany
 Legislation—Mrs. W. Holloway Bush.....Macon
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 Program—Mrs. Louie H. Griffin.....Claxton
 Research in Romance of Medicine—Mrs. Hayward S. Phillips.....Augusta
 Rural Health—Mrs. John D. Farris.....Waycross
 Safety—Mrs. W. Justus Gower.....Thomaston
 State Handbook—Mrs. Remer Y. Clark.....Marietta
 William R. Dancy Student Loan Fund—Mrs. F. N. Harrison.....Augusta

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Crawford W. Long Note Paper—Mrs. E. V. Patrick.....Carrollton
 Georgia Medical Political Action Committee
 (GaMPAC)—Mrs. John L. Elliott.....Savannah

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 Second—Mrs. Abram O. Goldsmith.....Albany
 Third—Mrs. Martin L. Malloy.....Vienna
 Fourth—Mrs. James M. Skinner.....Griffin
 Fifth—Mrs. John T. Leslie.....Decatur
 Sixth—Mrs. Thomas L. Ross, Jr.....Macon
 Seventh—Mrs. Oliver W. Jenkins.....Glendale
 Eighth—Mrs. R. A. Pumpelly.....Jesup
 Ninth—Mrs. Charles R. Andrews.....Canton
 Tenth—Mrs. Theodore Everett.....Augusta

Councilor, Woman's Auxiliary to the Southern Medical Association

Mrs. Luther H. Wolff.....Columbus

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 Bibb—Mrs. Richard B. Ewing.....Macon
 Bulloch-Candler-Evans—Mrs. Louie H. Griffin.....Claxton
 Carroll-Douglas-Haralson—Mrs. Jack Birge.....Carrollton
 Chatham—Mrs. Julian K. Quattlebaum, Jr.....Savannah
 Chattahoochee—Mrs. James S. Mashburn.....Cumming
 Cherokee-Pickens—Mrs. James Roper.....Jasper
 Cobb—Mrs. Roy G. Duncan.....Marietta
 Coffee—Mrs. Disken G. Morgan.....Douglas
 Colquitt—Mrs. Fred D. Cheney.....Moultrie
 Crawford W. Long—Mrs. Dillard Nix.....Athens
 DeKalb—Mrs. Frank E. Morgan, Jr.....Decatur

Dougherty—Mrs. John E. Meier.....Albany
 Elbert-Franklin-Hart—Mrs. Stewart D. Brown, Jr.....Royston
 Flint—Mrs. Kelvin Lane.....Ashburn
 Floyd—Mrs. E. Wayne Culbreth.....Rome
 Fulton—Mrs. William J. Pendergrast.....Atlanta
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 Gordon—Mrs. Charles R. Richards.....Calhoun
 Habersham—Mrs. Thomas L. Hodges.....Clarksville
 Hall-Lumpkin—Mrs. A. Frederick Bloodworth.....Gainesville
 Mitchell—Mrs. Laurier E. Hackett.....Camilla
 Muscogee—Mrs. Lee Roy Conn.....Columbus
 Ocmulgee—Mrs. Richard L. Smith.....Cochran
 Peach Belt—Mrs. E. Faxton Seay.....Marshallville
 Richmond—Mrs. Clyde Burgamy.....Augusta
 South Georgia—Mrs. Robert Quattlebaum.....Valdosta
 Southwest Georgia—Mrs. Homer Lassiter.....Arlington
 Spalding—Mrs. G. E. Black.....Griffin
 Stephens—Mrs. James C. Dudley, Jr.....Toccoa
 Sumter—Mrs. W. F. Castellow.....Americus
 Thomas-Brooks—Mrs. M. G. Middleton.....Thomasville
 Tift—Mrs. H. E. Aderholt.....Tifton
 Troup-Heard—Mrs. Charles T. Cowart.....LaGrange
 Upson—Mrs. J. Morgan Kellum.....Thomaston
 Walker-Catoosa-Dade—Mrs. Jerome Sims.....Rossville
 Ware—Mrs. Neal F. Yeomans.....Waycross
 Washington—Mrs. William Rawlings.....Sandersville
 Wayne—Mrs. Fred Harper.....Jesup
 Whitfield-Murray—Mrs. Calvin L. Edwards.....Dalton
 Worth—Mrs. W. P. Stoner.....Sylvester

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Honorary Presidents for Life

Mrs. James N. Brawner, Sr., Atlanta
 Mrs. Eustace A. Allen, Atlanta

1924—Augusta (Organization)—Mrs. C. W. Roberts.....Atlanta
 1925—Atlanta—Mrs. James N. Brawner, Sr.....Atlanta
 1926—Albany—Mrs. William H. Myers.....Savannah
 1927—Athens—Mrs. C. W. Roberts.....Atlanta
 1928—Savannah—Mrs. Paul Holiday (Mrs. J. C. Moore, Gaffney, S. C.)
 1929—Macon—Mrs. Charles C. Hinton.....Macon
 1930—Augusta—Mrs. Marion T. Benson (deceased).....Atlanta
 1931—Macon—Mrs. Charles C. Harrold (deceased).....Macon
 1932—Savannah—Mrs. Ralston Lattimore.....Savannah
 1933—Macon—Mrs. S. T. R. Revell.....Louisville
 1934—Augusta—Mrs. J. Bonar White (deceased).....Atlanta
 1935—Atlanta—Mrs. J. E. Penland.....Waycross
 1936—Savannah—Mrs. Ernest R. Harris (deceased).....Winder
 1937—Macon—Mrs. W. R. Dancy.....Savannah
 1938—Augusta—Mrs. Ralph H. Chaney.....Augusta
 1939—Atlanta—Mrs. Warren A. Coleman.....Eastman
 1940—Savannah—Mrs. Eustace A. Allen.....Atlanta
 1941—Macon—Mrs. H. G. Baccister.....Ila
 1942—Augusta—Mrs. Lee Howard.....Savannah
 1943—Atlanta—Mrs. J. Lon King.....Macon
 1944—Savannah—Mrs. Olin S. Cofer.....Atlanta
 1945—No Convention
 1946—Macon—Mrs. W. T. Randolph.....Winder
 1947—Augusta—Mrs. W. Bruce Schaefer.....Toccoa
 1948—Atlanta—Mrs. W. G. Elliott.....Cuthbert
 1949—Savannah—Mrs. S. A. Anderson.....Atlanta
 1950—Macon—Mrs. J. Harry Rogers.....Atlanta
 1951—Augusta—Mrs. Lehman W. Williams.....Savannah
 1952—Atlanta—Mrs. J. R. S. Mans.....Macon
 1953—Savannah—Mrs. Ralph W. Fowler.....Marietta
 1954—Macon—Mrs. Leo Smith.....Waycross
 1955—Augusta—Mrs. Shelley C. Davis.....Atlanta
 1956—Atlanta—Mrs. Robert C. Major.....Augusta
 1957—Savannah—Mrs. Walker L. Curtis.....College Park
 1958—Macon—Mrs. John L. Elliott.....Savannah
 1959—Augusta—Mrs. Luther H. Wolff.....Columbus
 1960—Columbus—Mrs. Remer Y. Clark.....Marietta
 1961—Atlanta—Mrs. W. P. Rhyne.....Albany
 1962—Savannah—Mrs. A. Worth Hobby.....Atlanta

Convention Committees

WOMAN'S AUXILIARY TO THE GLYNN COUNTY MEDICAL SOCIETY

General Chairmen

Mrs. C. S. Britt, St. Simons Island, *General Chairman*
 Mrs. Willard Snyder, Brunswick, *Co-Chairman*

Credentials and Registration

Mrs. Robert E. Perry, Jr., *Chairman*
 Mrs. W. Jackson Smith, *Co-Chairman*
 Mrs. Peter Grosgart; Mrs. Neal Yeomans, Waycross;
 Mrs. Fred Harper, Jesup

Executive Board Meetings

Mrs. Frank B. Mitchell, Jr., *Pre-Convention*
Mrs. Dwight Brown, Jr., *Post-Convention*

Flowers and Decorations

Mrs. James M. Hicks, *Chairman*
Mrs. Robert H. Thompson, *Co-Chairman*

General Meetings

Mrs. Joe L. Owens, *Chairman*
Mrs. Joseph B. Mercer, *Co-Chairman*
Mrs. Marvin F. Engel, Mrs. Roy F. Thagard, Mrs. W. W. Payne,
Mrs. Dwight J. Brown, Mrs. C. B. Chandler

Hospitality

Mrs. Erwin R. Jennings, *Chairman*
Mrs. Benjamin J. Addison, *Co-Chairman*
Mrs. C. B. Chandler, Mrs. C. D. Greer,
Mrs. Frank B. Mitchell, Jr.

Luncheon and Fashion Show

Mrs. Bert Ellis, *Chairman*
Mrs. Ben Moore, *Co-Chairman*

Recognition Luncheon

Mrs. Robert B. Crichton, *Chairman*
Mrs. Carl W. Lupo, *Co-Chairman*

Past Presidents' Luncheon

Mrs. Thomas W. Collier

Publicity

Mrs. Jesse L. Hunt, *Chairman*
Mrs. Milledge Smith, *Co-Chairman*

President's Banquet

Mrs. W. O. Inman, *Chairman*
Mrs. W. W. Payne, *Co-Chairman*

Transportation

Mrs. Bert H. Malone, *Chairman*
Mrs. C. A. Wilson, Jr., Mrs. W. F. Austin, Mrs. Mack Simmons,
Mrs. Howard M. Coe

Tellers

Mrs. W. F. Austin, Mrs. George B. Wheeler

Timekeepers

Mrs. Robert B. Crichton, Mrs. Clyde Wilson

Memorial

Mrs. Edgar M. Dunstan, Decatur

Pledge of Loyalty to the

Woman's Auxiliary Medical Association of Georgia

"I pledge my loyalty and devotion to the Woman's Auxiliary to the Medical Association of Georgia. I will support its activities, protect its reputation, and ever sustain its high ideals."

Collect

"Keep us, O God, from pettiness; let us be large in thought, word and deed. Let us be done with faultfinding, and leave off self-seeking. May we put away pretense, and meet each other face to face, without self-pity and without prejudice.

May we never be hasty in judgment, and always generous. Let us take time for all things; make us to grow calm, serene, gentle.

Teach us to put into action our better impulses, straightforward and unafraid. Grant that we may realize it is the little things that create differences; but in the big things of life we are one.

And, may we strive to reach and to know the great, common woman's heart of us all, and O, Lord, let us not forget to be kind."

Rules to Govern the Convention

1. The voting body of the convention shall consist of the members of the Executive Board of the Woman's Auxiliary to the Medical Association of Georgia and the duly accredited delegates from the county auxiliaries. No one is entitled to vote until registered.
 2. To gain recognition, a delegate is requested to rise, address the chair, give her name and the name of her auxiliary.
 3. No delegate shall speak more than twice on the same subject, and is limited to two minutes each time.
 4. Badges must be worn by members of the voting body during all general sessions of the convention.
 5. Delegates' privileges are not transferable.
 6. All motions shall be presented in writing to the Recording Secretary. They shall be signed by the persons making and seconding the motion.
 7. All original motions on resolutions shall be made by submitting two copies, one to the Resolution Committee and one to the Recording Secretary.
 8. All persons appearing on the program must be seated near the platform when the session opens.
- Whispering greatly retards the business of the meeting. Order must be maintained at all times. Please be prompt. Meetings will begin promptly at the time announced.

The Program

SUNDAY, MAY 5

11:00 Registration

to
5:00 *Patio, Buccaneer Motel* (Lobby if raining)

Hospitality

1:00 Pre-Convention Executive Board Meeting—Dutch Luncheon

Buccaneer

PRESIDING

Mrs. Ennis W. Waldemayer

INVOCATION

Mrs. C. James Roper, Jasper

PLEDGE OF LOYALTY AND COLLECT

Mrs. Clyde A. Burgamy, Augusta

5:00 Joint Meeting—MAG House of Delegates and Woman's Auxiliary

Aquarama

ORDER OF BUSINESS (*See MAG House of Delegates Handbook*)

REPORT OF PRESIDENT WOMAN'S AUXILIARY TO MAG

Mrs. Ennis W. Waldemayer, Americus

"Socialized Medicine"

James W. Harkess, M.D., Augusta,
formerly of Edinburgh, Scotland

MONDAY, MAY 6

8:30 Registration

to
3:30 *Patio, Buccaneer Motel* (Lobby if raining)

9:00 General Meeting

Buccaneer Room

CALL TO ORDER

Mrs. Ennis W. Waldemayer

MEDITATION

Mrs. John L. Elliott, Savannah

PLEDGE OF LOYALTY AND COLLECT

Mrs. W. J. Pendergrast, Atlanta

ADDRESS OF WELCOME

Mrs. William O. Inman, Jr., Brunswick,
President, Woman's Auxiliary to the
Glynn County Medical Society

RESPONSE TO WELCOME

Mrs. John A. Meier, Albany, President,
Woman's Auxiliary to the Dougherty
County Medical Society

PRESENTATION OF CONVENTION PLANS
Mrs. Charles S. Britt, St. Simons, General
Convention Chairman

INTRODUCTION OF PAGES FOR THE DAY
Mrs. E. R. Jennings, Brunswick

REPORT OF ADVISORY COMMITTEE TO THE
WOMAN'S AUXILIARY TO MAG
Ralph W. Fowler, Sr., M.D., Marietta

GREETINGS

Thomas W. Goodwin, M.D., Augusta,
President, MAG

George R. Dillinger, M.D., Thomasville,
President-Elect, MAG

INTRODUCTION OF PAST PRESIDENTS,

HONOR GUESTS AND GUEST SPEAKER
Mrs. Leo Smith, Waycross

ADDRESS

Paul B. McCleave, L.L.D., Director,
Department of Medicine and Religion,
A.M.A., Chicago

Business Session

CONVENTION RULES OF ORDER

Mrs. Leo Smith, Waycross, Parliamentarian

ROLL CALL

MINUTES

Mrs. S. William Clark, Jr., Waycross,
Secretary

REPORTS:

President

Mrs. Ennis W. Waldemayer, Americus
President-Elect

Mrs. John E. Porter, Savannah

Treasurer (including Auditor's Report)
Mrs. John T. Godwin

ADDENDUM REPORTS:

Complete Reports (*As given in 1962-1963 Annual Report Book*)

Recommendations from the Executive
Board Revisions

Mrs. C. James Roper, Jasper, Chairman,
By-Laws and Procedures

Report of Credentials Committee

Mrs. Robert E. Perry, Jr., Brunswick

ANNOUNCEMENTS

RECESS OF SESSION

12:30 Recognition Luncheon (Dutch)

Wanderer Motel

**Honoring County Presidents and District
Councilors (all attending convention
invited)**

PRESIDING

Mrs. John E. Porter, Savannah,
President-Elect

12:30 Dutch Luncheon
(For Past Presidents of Woman's Auxiliary to the MAG)
Corsair Motel

PRESIDING

Mrs. A. Worth Hobby, Atlanta, Immediate
Past President

AFTERNOON OPEN FOR RECREATION

TUESDAY, MAY 7

8:30 Registration
to *Patio, Buccaneer Motel* (Lobby, in case of
11:30 rain)

Hospitality

TO BE ANNOUNCED

9:00 Continued General Meeting

Buccaneer Room, Buccaneer Motel

CALL TO ORDER

Mrs. Ennis W. Waldemayer, Americus,
President

IN MEMORIAM: A DEVOTIONAL

Mrs. Edgar M. Dunstan, Decatur

A MOMENT OF SILENCE

PLEDGE OF LOYALTY AND COLLECT

Mrs. Julian K. Quattlebaum, Savannah,
President, Woman's Auxiliary to the
Chatham County Medical Society

INTRODUCTION OF PAGES FOR THE DAY

Mrs. E. R. Jennings, Brunswick, Hospitality
Chairman

ANNOUNCEMENT OF CONVENTION PLANS

Mrs. Willard Synder, General Convention
Co-Chairman

Business Session

ROLL CALL AND MINUTES

Mrs. S. William Clark, Jr., Waycross,
Secretary

REPORT OF REVISIONS COMMITTEE

Mrs. C. James Roper, Jasper, Chairman

REPORT OF BUDGET AND FINANCE
COMMITTEE

Mrs. John A. Meier, Albany, Chairman

REPORT OF RESOLUTIONS COMMITTEE

Mrs. Richard B. Ewing, Macon

REPORT OF CREDENTIALS COMMITTEE

Mrs. Robert E. Perry, Jr., Brunswick

REPORT OF COURTESY COMMITTEE

Mrs. J. Morgan Kellum, Thomaston

REPORT OF AWARD COMMITTEES

Achievement

Mrs. Floyd R. Sanders, Jr., Decatur

Civil Defense

Mrs. F. Kells Boland, Jr., Atlanta,
Chairman

Doctors' Day

Mrs. Carl S. Savage, Sr., Montezuma,
Chairman

Mrs. J. Bonar White Scrapbook

Mrs. D. L. Head, Jr., Thomaston,
Chairman

Safety

Mrs. W. Justus Gower, Thomaston,
Chairman

Brawner Trophy for General Excellence

Mrs. A. Worth Hobby, Atlanta, Chairman

REPORT OF NOMINATING COMMITTEE

Mrs. W. P. Rhyne, Albany, Chairman

ELECTION OF OFFICERS

INSTALLATION OF OFFICERS

Mrs. Leo Smith, Waycross, Parliamentarian

PRESENTATION OF PAST PRESIDENTS' PIN
AND GAVEL

Mrs. Ennis W. Waldemayer, Americus,
Retiring President

INAUGURAL ADDRESS AND ANNOUNCEMENT
OF 1963-1964 CHAIRMANSHIPS

Mrs. John E. Porter, Savannah

PRESENTATION OF PAST PRESIDENT'S PIN

Mrs. A. Worth Hobby, Atlanta

ANNOUNCEMENTS

ADJOURNMENT PROMPTLY AT 12 NOON

**1:00 Luncheon and Fashion Show at the
Cloister Hotel for all Auxiliary
Members**

(Fashion Show by Davison's of
Sea Island)

PRESIDING

Mrs. Ennis W. Waldemayer, Americus,
Retiring President

WEDNESDAY, MAY 8

**9:00 Post-Convention Executive Board
Meeting—Dutch Breakfast**

(For 1963-64 Officers, Chairmen, District
Councilors, County Presidents, County
Presidents-Elect, Past Presidents and
Councilor to SMA)

The Buccaneer

PRESIDING

Mrs. John E. Porter, Savannah, President

ADJOURNMENT TO 38TH ANNUAL MEETING

JOINT SESSION . . . *Aquarama*

(All MAG, Auxiliary Members and
Guests)

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Atha, William J., Jr.	Franklin, Georgia	Active	Troup
Billings, Richard A.	236 Auburn Avenue, N.E. Atlanta 3, Georgia	Active	Fulton
Brown, Edward B.	408 Zachry Street Waycross, Georgia	Active	Ware
Brylski, James R.	Grady Memorial Hospital Atlanta, Georgia	DE 2	Fulton
Carswell, Nelson S., Jr.	430 Academy Avenue Dublin, Georgia	Active	Laurens
Carter, Harvey P.	Crawford W. Long Hospital Atlanta, Georgia	DE 2	Fulton
Deitch, Milton J.	Grady Memorial Hospital Atlanta, Georgia	DE 2	Fulton
Feldman, Donita J.	69 Butler Street, S.E. Department of Pediatrics Atlanta 3, Georgia	DE 2	Fulton
Griffin, Richard, III	Piedmont Hospital Atlanta, Georgia	DE 2	Fulton
Jaramillo, Carlos A.	Memorial Hospital of Chatham Co. Savannah, Georgia	Active	Ga. Med. So.
Kibler, James A.	Medical Arts Center Dublin, Georgia	Active	Laurens
Kibler, Robert F.	Grady Memorial Hospital Atlanta, Georgia	Active	Fulton
Lea, James W., Jr.	1837 Walthall Drive, N.W. Atlanta 18, Georgia	Active	Fulton
Mrazek, Svatopluk	Doctors Building Palmetto, Georgia	Active	Fulton
Per-Lee, John H.	Emory University Clinic Box 459 Atlanta 22, Georgia	DE 2	Fulton
Quinn, David Edman	600 N. Jefferson Street Dublin, Georgia	Active	Laurens
Sheffield, Charles R.	Johnson Street Dawson, Georgia	Active	Randolph-Terrell
Simmons, John W., III	341 West Ponce de Leon Avenue Decatur, Georgia	Active	DeKalb
Smith, Robert R.	Winship Clinic Emory University Hospital Atlanta 22, Georgia	Active	Fulton
Snell, Henry M.	62 Butler Street, S.E. Atlanta, Georgia	DE 2	Fulton
Toole, William N.	Emory University Clinic Atlanta 22, Georgia	Active	Fulton
Turner, Joseph M.	Grady Memorial Hospital Atlanta, Georgia	DE 2	Fulton
Whitesides, Thomas E.	Emory University Clinic P. O. Box 459 Atlanta 22, Georgia	Active	Fulton



PRESIDENT'S LETTER

"ROOM FOR IMPROVEMENT"

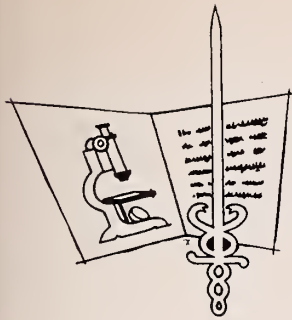
Thomas W. Goodwin, M.D.

NOT SO LONG AGO I had to spend the day in court. The case in question was a traffic accident in which there was considerable divergence of opinion among the medical witnesses as to how badly the victim had been hurt and as to whether or not any permanent disability existed. I wasted the whole day there, often at odds with some of my friends. In the end the jury had to decide on matters which should have been decided by doctors. The time of the lawyers involved and the time of the court was also wasted and the whole thing seemed to me to be expensive to the taxpayers and unnecessary.

In some states now, such matters are being handled by impartial, objective medical testimony. This is given by a panel of qualified experts in the various fields of medicine. This panel is a rotating one and is appointed by the courts and paid by the courts. They meet and examine all clients involved in litigation, determine the extent of the injury and disability and so testify. This testimony is unbiased and is based on medical facts only. The time of the doctors as well as the lawyers and the courts is saved. The taxpayers are saved unnecessary expense and the verdicts rendered are usually much fairer and realistic than those rendered under the old system of the partisan medical witness.

With the cooperation of the Georgia Bar Association and the courts, this could be worked out for the mutual benefit of all as well as for the benefit of our patients. How about it?

Thomas W. Goodwin
President, Medical Association of Georgia



CANCER OF THE LUNG

Richard King, M.D., *Atlanta*

CANCER OF THE LUNG is now the most frequent cancer and supersedes cancer of the breast. A brief review of clinical facts of cancer of the lung should be helpful to the medical profession.

In regard to etiology, atmospheric pollution, occupational hazards, and cigarette smoking have been mentioned as causes of bronchogenic cancer. Both the statistical and experimental evidence that is accumulating emphasize the causal relationship between cigarette smoking and cancer of the lung. One of the most authentic statistical studies to date was conducted by the American Cancer Society on 200,000 men. This study revealed that the deaths per 100,000 population were: nonsmokers, 3.4; less than one-half pack of cigarettes daily, 51.4; one-half to a pack, 59.3; one to two packs, 144; and over forty cigarettes, 217. There also was statistical evidence that the tendency to develop lung cancer diminishes after discontinuance of smoking. The above study showed that although the lung cancer death rate to 100,000 population was 3.4 among nonsmokers, it was 57.6 among those who smoke less than a pack a day and who continued smoking. For those who had stopped less than ten years, it was 35.5, and for those who stopped over ten years it was 8.3.

Symptoms

The most frequent symptoms of cancer of the lung in the approximate order of occurrence are: cough, weight loss, chest pain, hemoptysis, dyspnea, respiratory infections, weakness, wheezing, chills and fever, night sweats, voice change, and dysphagia. The patient's cough is usually ignored because he looks upon it as a "cigarette cough." The patient should be asked, however, has his cough changed in character and has it become more severe. Unfortunately, hemoptysis is sometimes the first

symptom that will encourage a patient to see a physician, and the fact that it may have occurred only once should not discourage the physician to be aware of the possibility of cancer of the lung and proceed with the usual diagnostic procedures. "All that wheezes is not asthma." When it does occur, it should be given due consideration, particularly if it is localized.

Frequent Complaints

One of the most frequent presenting complaints from a patient is that sometime previously he had a "virus infection" or a "virus pneumonia." Any patient who does not show evidence of his lungs clearing on X-ray and clinically two weeks after the onset of a virus infection or pneumonitis, should be bronchoscoped. Usually bronchoscopy will help clear the common types of infections in the lung, but all cases over 40 years of age who do not show evidence of clearing on repeat X-rays a week after bronchoscopy, exploratory thoractomy should be considered.

The presenting complaints of patients with unsuspected lung cancer may be extremely variable. Joint pains may be the chief complaint, and if the cause is unexplained the patient deserves a chest X-ray. Any patient with unexplained neurological or gastrointestinal symptoms deserves an adequate study of his lungs to rule out cancer.

Diagnosis Not Difficult

The diagnosis is not always difficult if the physician will consider the clinical facts and the possibility that a bronchogenic carcinoma might be present. Although it is presumptive evidence, our best means of diagnosis is X-ray of the chest. This

should include both posteroanterior and lateral views, because in the absence of a lateral film an occasional shadow is missed lying back of the heart. One of the frequent errors in diagnosis is for the physician to ignore the presence of a solitary pulmonary nodule in the lung. The patient may be told that the lesion will be "watched" and that he should return at a later date, although he is not always given a date for another check-up. Since the majority of patients with a peripheral solitary pulmonary nodule are asymptomatic, they frequently will not return because they feel quite well. Any patient who has an undiagnosed solitary pulmonary nodule which is not completely stippled with calcium, or has concentric rings of calcium throughout, or has a large central calcified core should be considered for exploration. The presence of a few flecks of calcium certainly does not negate the possibility of the presence of cancer.

Analysis

An analysis of a combined series of solitary pulmonary nodules was presented by Dr. Edgar W. Davis, et al. *The Journal of Thoracic Surgery*, December 1956. The combined group included 1203 solitary nodules and of this number 36.7 per cent proved to be malignant lesions. "Taking the bronchogenic carcinomas and bronchial adenomas together, which is amply justified by the malignant potentialities of the adenomas, the percentage of actual and potential primary carcinomas of the lung is almost exactly 30 per cent. Metastatic tumors numbered 69. It would appear, therefore, that the chance of any solitary pulmonary nodule being malignant is almost 40 per cent; the chance of its being bronchogenic carcinoma, around 30 per cent." 41.6 per cent of this entire series was diagnosed as granuloma. If a previous X-ray shows that the nodule is of recent origin, this

is strongly suggestive of malignancy; however, many of the patients have never had an X-ray of the chest or the X-ray cannot be located; therefore, the physician does not have the advantage of knowing how long the lesion has been present. The mortality for exploration of the chest and limited resection is almost zero, and the low mortality rate following a more radical resection should be convincing proof of the safety in exploring every patient with a solitary noncalcified pulmonary nodule.

Value of Bronchoscopy

Bronchoscopy is of little diagnostic value in the peripherally situated solitary pulmonary nodule, but in the lesion which lies in the vicinity of the hilum it is one of our best definitive diagnostic procedures. A needle biopsy should never be done except in the case that is considered inoperable and the procedure is done only to make a diagnosis.

Due to the fact that approximately 90 per cent of the patients with tuberculosis are now arrested by the administration of antituberculosis drugs, more cases of tuberculosis are seen in the elderly patients. It is known that pulmonary tuberculosis and cancer of the lung can occur together and the elderly patient with tuberculosis should be observed very closely.

The diagnosis of cancer of the lung is not too difficult if the physician will keep in mind constantly the symptoms and signs of lung cancer and encourage his patient to have routine chest X-rays. Many death certificates have been signed verbally by the physician stating to the patient, "Let's watch it." This is one of the greatest pitfalls in diagnosis of lung cancer and increases the time from onset to exploratory thoractomy. In order to cure more patients with cancer of the lung the chest surgeon must see the patients earlier.

340 Boulevard, N.E.

Approved by the Professional Education Committee, Georgia Division, ACS.

THREE ATLANTA HOSPITALS CONTINUE SEMINARS

On the second Sunday of each month, the Independent Non-Profit Hospitals (INH) of Atlanta present a seminar on the fundamental mechanisms of disease in its program of continuing education for the physician.

The program is sponsored by Georgia Baptist Hospital, Piedmont Hospital and St. Joseph's Infirmary and is supported in part by a grant-in-aid from the Merck Sharp & Dohme Postgraduate Program and established for house officer and physician education. These pro-

grams are held at the Academy of Medicine. No registration fee is required.

Future Programs:

March 10—"Hereditary Metabolic Disorders."

April 14—"The Approach to the Pulmonary Problem."

May 12—"Basic Hormone Effects on the Female."

June 9—"Virology: Its Background in Current Clinical Concepts."



THE NATURAL HISTORY OF ISOLATED VENTRICULAR SEPTAL DEFECT

B. Waldo Moore, M.D., *Atlanta*

THE NATURAL HISTORY of isolated ventricular septal defect is variable and is yet poorly defined. Several papers have appeared in the past few years attempting to clarify this problem. The need for a better understanding is great. The technical ability to close a ventricular septal defect has been well demonstrated in recent years at many medical centers throughout the world. Since the advent of open heart surgery, there has been an understandable enthusiasm on the part of the surgeons to repair these defects, and the surgeon has received substantial encouragement by the referring cardiologist.

Benign Course

We have all observed the benign course of ventricular septal defect in patients. It remained for Azevedo in 1958 to report the first spontaneous closing ventricular septal defect. A similar report has been made by Evans, and a recent report by Nadas reported the spontaneous closure of hemodynamically significantly ventricular septal defects. All four of Nadas' cases had manifestations of heart failure in infancy, and in two of his cases there was evidence of right ventricular hypertension in the systemic range at the time of the first catheterization. These, then, represented spontaneous corrections, not of Roger's disease, but of hemodynamically significantly ventricular septal defects. Pulmonary hypertension disappeared to a significant degree in three of his four patients.

Conservative Approach

The conservative approach to the problem of ventricular septal defect would be supported by Fyler's work. He recently reported 23 patients, reviewing

the literature of 116, which had had serial catheterizations. If one could eliminate one series of data in which the findings were inconsistent, the increase in pulmonary arterial pressure was approximately 3.7 per cent two to seven years after initial catheterization. This study certainly indicated, along with the other reported series, that the pulmonary arterial pressure in children with ventricular septal defects did not usually increase with advancing age. The therapeutic implications were clearly that a conservative approach to the infant or child with the ventricular septal defect was possible without undue risk of progressive pulmonary hypertension.

Another recent study of Lillehei, Adams and others reporting on the findings of 57 patients who had preoperative catheterizations and postoperative catheterizations after an interval of one year and ten months, who had had successful closure of ventricular septal defects, demonstrated that the fall in pulmonary artery pressure after surgery was in direct proportion to the decrease in pulmonary blood flow affected by the surgical closure of the ventricular septal defect. They reported no evidence to indicate regression toward normal pulmonary vascular bed in the first year or two after closure of the defect.

Physical Studies

Lucas has reported 40 patients with isolated ventricular septal defect who were studied physiologically before they underwent surgical treatment. He recognized a high mortality rate of ventricular septal defect with congestive heart failure ensuing before six months of age as being approximately 25 per cent during the first two years of life when treated medically. He also realized the increased operative

mortality among infants especially during the first year or two of life. There is little virtue in reflecting on the mortality rate for surgical closure of ventricular septal defect at a distant medical center where the patient will not experience surgery. The mortality experiences of the operating surgeon involved is the important factor. This report is not to magnify the uncertainties of the surgical approach nor to

minimize the less favorable aspects of the natural history of ventricular septal defect which are present when the patient is treated medically. We really need to know what the long term outlook for a surgically corrected interventricular septal defect may be. And most important of all, there has yet been a large series of unselected ventricular septal defects analyzed to see what the natural history of this illness may be without surgery.

1285 Peachtree Street, N.E.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

Everyone can recall in that classic foot race between the rabbit and the turtle that the rabbit accustomed himself to frequent "rest" stops and ultimately came in second in a two man race. The rabbit didn't lack the speed to win. He simply failed to understand that a race isn't over until you cross the finish line and that you don't sit down until it is won.

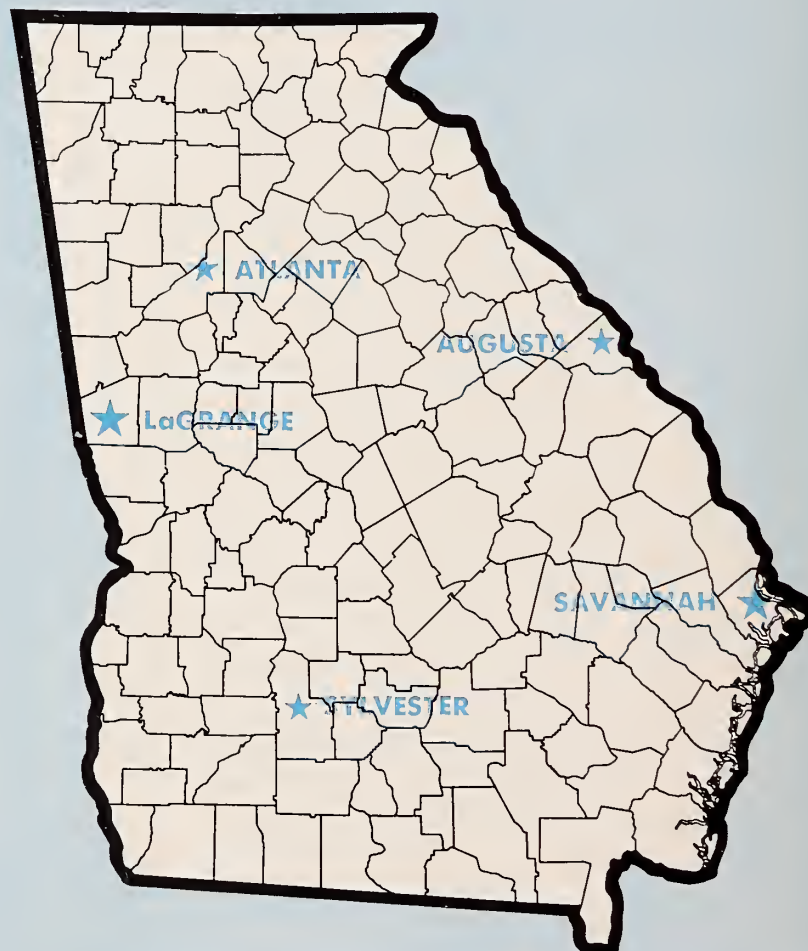
This story is not without parallel in medicine's fight against the advocates of Social Security Medicine. We out-distanced our opponents last year and won the first heat in the marathon King-Anderson derby. Now it appears that the medical profession in Georgia has been struck with a severe case of "rabbittitis." For the most part the profession seems content to rest on its accomplishments and do nothing until the matter once again becomes critical. This is a dangerous way to run this race. Like the rabbit, we may be sitting a little too long.

Last month our star map indicated a grand total of only two physician delivered speeches to the lay public on topics of concern to those groups. Our March map is some improvement. Not much, but some. Certainly a prudent man concerned over the image of his profession and alarmed over the frightening prospects of its failure to mobilize public opinion would have to consider this improvement negligible in the extreme.

Certainly everyone must realize that with the power we have, properly harnessed, we could bury King-Anderson type legislation under a mountain of adverse grass-roots support. What is so confounding about this thing is that so few are willing to assume their fair share of the load to help lay to rest such legislation. The great majority assumes that it is someone else's job. It's not. It's ours and we cannot abdicate our responsibility here any more than we can in practice.

The doctor standing alone makes a tempting target. From the standpoint of our numbers alone we couldn't hope to stem the tide of oppressive Federal regulation. The security of the profession rests solidly with our allies. With them we have little to fear. Without them we have little hope. The public wants to know and only we can tell them.

How well are we telling our story?





IMPASSE IN ADOLESCENCE

J. L. D. Cox, M.D., *Philadelphia, Pennsylvania*

IMPASSE AS DEFINED by Webster's is a blind alley; an insurmountable object; a position affording no escape. In their relationships with each other, adolescents and their parents sometimes reach an apparent impasse. Since they may react in some extreme unreasonable way or feel overwhelmed by helplessness and hopelessness, they often come for expert help. Since the form and meaning of the impasse may vary considerably it must be *diagnosed not only from its surface or manifest content but also from its latent or deeper meaning*. To arrive at this the physician must hear each side of the situation, being careful not to align himself beforehand too strongly with any one point of view. He must arrive at an impression of the healthy forces versus the unhealthy ones. Only through understanding the forces at work and judging which are most pathogenic for the impasse can the physician plan a specific course of action to appropriately treat the problem. In this article I will briefly show you three different ways I handled such impasse situations with some of my reasons.

Case One

In the first case I decided to initially treat the parents of an adolescent because the parental expectations and modes of dealing with the boy's problems were largely responsible for the intensity of this impasse. The crisis was precipitated by the boy's remaining out three days (sleeping on the porch) when the parents locked him out for lateness. To the parents there was no impasse, he was simply bad. They came only as a last resort before committing him to a reformatory. Two years before this childless couple had adopted him at age fourteen. The other points: losing his job, laziness, evasiveness and occasional lateness and lying

brought increasingly strict punishment during the last year.

During this year the boy associated more with a lower socioeconomic group. Though this had significance in light of his background, it did not seem the essential factor in this particular impasse. The parents, highly intelligent and competent, with apparently reasonable ideas about child rearing, were scarcely aware of the degree of their rage and anxiety. The father felt a need for the same complete control of the boy which he exercised in his highly responsible position. He felt either he or the boy would soon be physically flattened. The mother pressured him in the intellectual sphere which had major meaning for her own life. With increased tension and ultimatums, the boy verged on suicide.

Secondary Problem

In this situation, the boy's problems, though important, were secondary to the need of the parents. Short term therapy aimed at modifying the parents' need to control and their excessive expectation of him was given for several months prior to starting therapy with the boy. The parents, after their initial resentment at this recommendation, utilized psychotherapy effectively and became more relaxed and hence more effective parents to the boy.

Second Case

In the second case, though a complex family situation had a clear bearing on the adolescent's problem, it was the boy's panic that required immediate attention.

He, a seventeen-year-old, was involved in a very serious accident while impulsively running away from home. Prior to this, his father, though still interested, had ceased trying to control his son. Pre-

MENTAL HEALTH PAGE / Continued

vious once a week psychotherapy had been ineffective. For months prior to the accident the boy had felt, and had been, increasingly out of control (e.g., quitting school, a job, taking cars, staying out to all hours). Evaluation of the parents revealed each reliving his own childhood in the present situation. The father struggled with aggressive competitive feelings while the mother struggled with unconsciously seductive ones.

Basic Element

Despite the complex family situation, the basic elements here seemed to be the boy's poor control of his impulses that panicked him at times. Immediate psychiatric hospitalization afforded control for his behavior and removed him from the highly charged environment. With therapy aimed at re-establishing his own controls, the patient began to calm down.

Third Case

In the final case, a nineteen year old boy's passive infantile orientation seemed to be the key to an impasse of destruction tantrums, increasingly directed toward his parents. The consciously prim, though seductively infantilizing mother and the maternally dominated, passively hostile, sarcastic father, afforded no healthy aggressive model for this boy. Intense aggressive participation on the part of the therapist to modify this boy's orientation was elected.

Later, the family as a unit began therapy with

another therapist. The patient was strongly encouraged to bring his uncovered conflicts, memories and the underlying meaning of his behavior to those sessions. As he talked more openly his tantrums decreased. In this case the boy's patterning himself after a more aggressive male figure helped him to more effectively communicate. As he felt less helpless and less dominated, his reactive tantrums subsided. Further, the father became less fearful of being preempted and became more assertive and helpful, facilitating the boy's treatment.

Discussion and Summary

An impasse indicates some malfunctioning in the family either at the individual or family level. In determining the nature and level of the impasse, the physician must not let predetermined judgments influence his diagnosis. If his sympathies lie too strongly with the parental point of view he might fail to understand their etiological role in some impasses as in Case One. Once the forces in the situation are understood, the key to the solution is often at hand. In this paper I have touched on various ways of handling situations 1) attempting to modify parental attitudes 2) reasserting controls in a panic state and 3) identification with a more aggressive object and 4) family therapy. There are numerous ways, the important thing is that they be tailored to the diagnosed situation. Finally, though a physician offers hope and a willingness to find a way out, he must size up the clinical picture like any other complex, diagnostic problem, to give his most effective help.

404 South 47th Street

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

MEDICAL COLLEGE PRESENTS POSTGRADUATE COURSE

Office care and certain minor surgical procedures will be emphasized in the postgraduate course, GYNECOLOGIC PROBLEMS IN PRIVATE PRACTICE, March 12, 13, 14, 1963, to be held at the Medical College of Georgia.

The course covering subjects of interest in the management of the private gynecologic patient will also include functional and endocrine disturbances and certain aspects of infertility.

Simon V. Ward, M.D., Associate Clinical Professor of Obstetrics and Gynecology, Louisiana State University School of Medicine, New Orleans, Louisiana,

will be the featured faculty. Coordinator of the course is Preston Lea Wilds, M.D., Assistant Professor of Obstetrics and Gynecology, Medical College of Georgia. Faculty members of the Medical College of Georgia will participate.

Each course is acceptable for 18 hours credit by the American Academy of General Practice. Registration is limited to a small group for close faculty-participant communication. Registration fee is \$50.00. Application can be made by contacting, Dr. Claude-Starr Wright, Director, Department of Continuing Education, Medical College of Georgia, Augusta, Georgia.



PHYSICIAN'S BOOKSHELF

BOOKS RECEIVED

Lynch, Matthew J., M.D., **MEDICAL LABORATORY TECHNOLOGY**, W. B. Saunders Co., Philadelphia and London, 1963, 733 pp.

Bockus, Henry L., M.D., **GASTROENTEROLOGY**, Volume I, Second Edition, W. B. Saunders Co., Philadelphia and London, 1963, 958 pp.

Rogers, Joseph, M.D., **ENDOCRINE AND METABOLIC ASPECTS OF GYNECOLOGY**, W. B. Saunders Co., Philadelphia and London, 1963, 18 pp., \$8.00.

Warren, Richard, M.D., **SURGERY**, W. B. Saunders Co., Philadelphia and London, 1963, 1397 pp., \$19.50.

Hughes, James G., M.D., **SYNOPSIS OF PEDIATRICS**, The C. V. Mosby Co., St. Louis, Mo., 1963, 1031 pp., \$9.85.

Ciba Foundation Study Group No. 13, **RESISTANCE OF BACTERIA TO THE PENICILLINS**, Little, Brown & Co., Boston, 1963, 125 pp., \$2.95.

CIBA Foundation Symposium, **TRANSPLANTATION**, Little, Brown & Co., Boston, 1963, 426 pp., \$12.00.

McGregor, Ian A., M.D., **FUNDAMENTAL TECHNIQUES OF PLASTIC SURGERY AND THEIR SURGICAL APPLICATIONS**, The Williams and Wilkins Co., Baltimore, 1962, 286 pp., \$8.00.

Harper, Paul A., M.D., **PREVENTIVE PEDIATRIC PRACTICE**, Appleton-Century-Crofts, New York, 1962, 798 pp., \$14.95.

Fishbein, Morris, M.D., **YOUR WEIGHT AND HOW TO CONTROL IT**, Doubleday & Co., New York, 1963, \$3.95.

Grigor'eva, T. A., **THE INNERVATION OF BLOOD VESSELS**, Pergamon Press, New York, 1963, \$9.00.

Cusumano, Charles L., **MALPRACTICE LAW DISSECTED FOR QUICK GRASPING**, First Edition, Medicine-Law Press, Inc., New York, 1962, 132 pp., \$10.00.

MALPRACTICE LAW is a subject certain to demand the attention of medical doctors. A text has been needed for the practitioner's shelf to which he can turn for well-indexed advice on a day-to-day basis—and without retaining a lawyer to explain the text to him.

Despite the folksy title and somewhat frequent type-setting errors, this book supplies that need. The detailed table of contents is well-arranged to give the worried practitioner prompt access to the precise point. Basic principles of law are well explained with an obvious knowledge of how much law an educated medical doctor already knows. The text deserves immediate reading by all physicians for its helpful approach to preventive medicine to avoid malpractice claims.

Naturally, the text is written with reference to general principles of law and does not set out the particular governing precedents in Georgia. Accordingly, it cannot be used as a substitute for timely and competent legal advice in a given situation. However, used properly, it will be used often by every medical doctor in Georgia. It will also be used by the undersigned lawyer because it happens to be the best text available for the practicing lawyer.

John L. Moore, Jr.

Novak and Woodruff, **NOVAK'S GYNECOLOGIC AND OBSTETRIC PATHOLOGY**, Fifth Edition, W. B. Saunders Co., Philadelphia and London, 713 pp., \$16.00.

THIS IS THE FIFTH EDITION of the most widely read and most depended upon textbook of Gynecologic and Obstetric Pathology that the profession has had to date. This edition continues with the same format of the former editions that the late Dr. Emil Novak authored. Many new photographs, photomicrographs and drawings have been added, and most of those of the former editions have been retained, even a few drawings by the great medical artist, the late Max Brodel. There has been added a more comprehensive presentation of the topic of exfoliative cytology because of the increasing interest and importance of the subject. This is well done by Dr. John K. Frost. The subject of genital cancer is more completely considered.

The bibliographies have been brought up to date with newer ones being added and the older ones being deleted. The reproduction of the photomicrographs and color prints is excellent.

The authors of the present edition have somewhat changed, in chapter 20, the classification of ovarian tumors. Although there has never been completely satisfactory classification of ovarian tumors, this new attempt is seemingly an over-simplification, compared to that of Emil Novak. It is well that the great work of Emil Novak is being carried on capably by his son Edmund R. Novak, and one of his former gynecologic pathology laboratory residents, J. Donald Woodruff. It seems that this book will remain as the basic reference of gynecologic and obstetric pathology for some time to come.

John H. Ridley, M.D.

Meschan, Isadore, M.D., **SYNOPSIS OF ROENTGEN SIGNS**, W. B. Saunders Co., Philadelphia and London, 1962, 436 pp., \$11.00.

THE AUTHOR IS UNIQUE in his approach to diagnostic radiology. In contrast to the usual method—that of presenting the radiographic features of a specific disease entity—the differential diagnoses of particular radiographic findings in specific anatomic areas are enumerated and briefly discussed. Thus, there is a similarity to Dr. Meschan's earlier and well-known book, *Roentgen Signs in Clinical Diagnosis*.

This book is refreshingly succinct, and for a synopsis is fairly complete. Useful and important facts, charts and drawings are most generously provided, but discussion of disease processes with respect to etiology, pathogenesis and therapy is cursory and sparse. Controversial matters are held to a minimum, and are treated conservatively, though, of necessity, somewhat dogmatically. Diagrams and radiographs are abundant.

Although it offers a practical and logical approach to radiographic differential diagnosis, this publication, because of its brevity and conciseness, is too superficial to be of extraordinary value to the practicing radiologist. For the non-radiologist, it should provide an excellent

PHYSICIAN'S BOOKSHELF / Continued

guide by which a specific diagnosis could be suggested for correlation with clinical findings. Each chapter is summarized by a list of pertinent and basic questions, which serve the medical student admirably in directing his thinking to obtain a usable and meaningful concept of roentgenology. This synopsis provides a unique and practical birds-eye view of diagnostic radiology and would enhance the library of any clinician.

John W. Morris, M.D.

Chusid, Joseph G. and McDonald, Joseph J., CORRELATIVE NEUROANATOMY AND FUNCTIONAL NEUROLOGY, Eleventh Edition, Lange Medical Publications, Los Altos, Calif., 1962.

IT IS MOST SURPRISING that this manual has not received wider circulation in view of its broad coverage of virtually all conditions involving the central and peripheral nervous system. It is now in the eleventh edition and an Italian translation has just been published. Although the reviewer has had access to many books on neurology, neuroanatomy, etc., this is the first time he has encountered this particular volume.

The authors state very clearly their purpose, this

volume being "intended for the beginner in neurology and will serve him best if used as an aid or supplement to standard neurologic tests and literature." This statement is very modest, because the manual will serve very nicely as a review medium for any practitioner interested in lesions of the central nervous system, no matter how adequately trained and experienced he may be. The critical reader may be disappointed in the lack of detailed information made available, but, again, the objective of the authors should be remembered and the role as proposed is admirably fulfilled.

The contents cover the embryology, neuroanatomy, chemistry of the brain, spinal cord and peripheral nerves. A brief discussion of neurologic diagnostic tests, metabolic degenerative disorders, trauma and infections of the central nervous system is presented. It also covers in modest fashion various types of neurosurgical diagnostic procedures which can be utilized to more specifically determine a pathologic process. The text, various charts, drawings, diagrams, etc. are well chosen, representative, and informative.

It is a very fine manual for the novice, a handy reference for the professional and should prove invaluable to the casual student of diseases of the central nervous system.

Robert F. Mabon, M.D.

SMALLPOX PROTECTION URGED

America's protection against smallpox has reached a "dangerous low," the American Medical Association warned recently.

In a statement adopted by the House of Delegates at the association's clinical meeting in Los Angeles November 28, 1962, physicians and the public were urged to reverse, "the declining immunization level against smallpox."

The statement said:

"Maintenance of protection against this serious epidemic disease requires revaccination at five-year intervals.

"A growing amount of international travel, at increasing speeds, to and from areas of the world in which smallpox is prevalent, persistently threatens to introduce the disease into the United States. Recent outbreaks in other Western nations emphasize the need for attention to this problem.

"The American Medical Association, in the interests of national safety, urges physicians and their patients, particularly those who may be in contact with possible carriers, to maintain the needed protection against smallpox.

"In implementing this proven phase of preventive medicine, the American Medical Association solicits the cooperation of other health organizations and agencies."

A "perimeter defense" against the disease—the requirement for vaccination of people coming into the country, and public health surveillance of ports of entry—is not adequate when "the inner defense is weak," explained Dr. Raymond L. White, Director of Environmental Medicine for the AMA.

"Unfortunately false certificates have sometimes been issued overseas, or a vaccination has been certified be-

fore knowing that the vaccine has 'taken'," Dr. White said.

"There was an example of this in New York last summer. In England, where there was an epidemic earlier this year, health authorities have concluded that the disease was brought from Asia by travelers who had apparently valid vaccination certificates."

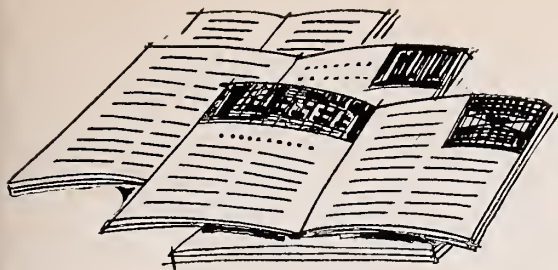
Smallpox, one of the "easiest diseases to prevent" he said, "is highly contagious. The virus can be spread by coughs and sneezes or even in dust. It has even been transmitted by letter." The disease often results in severe scarring of its victims, and death results in about one out of five cases.

Another problem in connection with smallpox arises from difficulty in early diagnosis. "This is compounded," said Dr. White, "by the fact that most doctors in the United States have never seen a case of the disease."

"With so much of our population lacking immunity, it only takes one case to touch off an epidemic," he said. "A wounded soldier, flown back to this country from Korea, started a chain of infection that spread to 100 people before it was discovered he had smallpox. Another traveler seeded 65 cases and caused 20 deaths after arriving from Japan, although when he landed he showed no symptoms of the disease." Rapid increase in the amount of international travel is steadily enlarging the risk of such epidemics in the United States.

Smallpox usually begins with a high fever eight to 14 days after exposure. This lasts about four or five days before the characteristic skin rash appears, in pustules or "pox."

The pustules appear not only on the skin, but also on the mucous membranes of the nose and mouth, and may appear in the intestines and certain other internal organs, leading to further complications.



Surgical Correction of Bladder-Neck Obstruction in Children

RECURRENT URINARY TRACT infection in children due to bladder-neck obstruction may respond to conservative urethral dilation, but failure to do so necessitates surgical bladder-neck reconstruction and possible repair of concomitant ureterovesical valves. Importance of early diagnosis in recurrent urinary tract infection is again stressed.

Gross, R. E.; Randolph, J., and Wise, H. M., Jr. *The New England Journal of Medicine*, 268:5, 1963.

Unilateral Adrenalectomy for Metastatic Bone Pain

"I NOTICED WITH SOME surprise that when we used to perform adrenalectomy, one side at a time for bony metastases from breast to carcinoma, many patients insisted the next day that their bony pain had vanished despite the discomfort of the wound. Last week a patient of mine whose general condition was poor, had a large pleural effusion and intolerable pain from the total destruction of L2, begged me to do something to relieve her pain. I removed her left adrenal gland with complete relief of pain. Why should unilateral adrenalectomy be so effective so quickly?"

Moroney, J.; *Lancet*—2:833, 1962.

Review of Recurrent Urinary-Tract Infections in Infancy and Early Childhood

RECURRENT URINARY TRACT infections in childhood rank second only to respiratory infections. It is probable that recurrent infections in children are not a series of isolated attacks but repetitive exacerbations of one underlying and continuous infection, and therefore require, especially in the first three years of life, early diagnosis.

DeLuca, F. G., Fisher, J. H. and Swenson, Orvar. *The New England Journal of Medicine*, 268: Vol. 2, 1963.

Extracellular Fluid In Hemorrhagic Shock

THE LOSS OF EXTRACELLULAR fluid in acute hemorrhagic shock is much greater than clinically anticipated. Rapid replacement with Ringer's Lactate in moderately large volumes, in addition to whole blood, produces best results in treatment of shock.

In regards to the development of thrombophlebitis as a result of ENVOID® therapy, there is no evidence that the above drug is an etiologic agent. The incidence of phlebitis in ENVOID users is no greater than in normal population.

"Current Status of Homotransplantation"

Panel Discussion

In particular reference to renal transplants it was stated that total body irradiation has not been satisfactory. It is believed that desensitization of the recipient by drugs will prove to be most satisfactory. . . . unless identical twins are used, an unrelated *live* donor is preferred. . . . in general: Panel proved to be pessimistic of the long range outlook of homotransplantation, and stated that it is still very much in the experimental stage.

American College of Surgeons Clinical Congress, October 15-19, 1962, Atlantic City, N. J.

Cholecystectomy for Acute Cholecystitis and Common Duct Exploration

SIX STEPS EMPHASIZED in the operative procedure:

1. Decompression of tense inflamed gall bladder by aspiration.
2. Placing a ligature about the cystic duct.
3. Temporary ligation of cystic artery proximal to its bifurcation.
4. Dissection of gall bladder from its capsule, beginning at fundus and proceeding toward the cystic duct.
5. Common duct exploration, failing to reveal renal calculi.
6. Common duct drainage by small catheter introduced through cystic remnant.

Glenn, Frank, M.D., and Thorbparnarosn, Bjorn, M.D.: Cholecystectomy for Acute Cholecystitis and Common Duct Exploration. Taken from the Surgical Film Program at the American College of Surgeons Meeting in Atlantic City, 1962.

Problems in the Surgical Management of Hyperparathyroidism

WHEN THE DIAGNOSIS of primary hyperparathyroidism has been made, the obscure and variable positions of the parathyroid glands require for their search and identification adequate exposure, meticulous hemostasis, careful dissection, and a detailed

CLINICAL CONCEPTS / Continued

working knowledge of the anatomical relationships and anomalies of the neck and mediastinum. One of the most perplexing problems is the number of lesions found in the deeper recesses of the neck and mediastinum such as ectopic thyroid nodules, cystadenomas of thyroid, hyperplastic lymph nodes, etc., which may closely resemble a parathyroid adenoma in gross appearance.

Altemier, William A., M.D., and Wulsin, John H., M.D.: Problems in the Surgical Management of Hyperparathyroidism. Taken from the Surgical Film Program at the American College of Surgeons Meeting in Atlantic City, 1962.

Sphincterotomy for Stenosis of the Sphincter of Oddi

ALTHOUGH SOME CLINICIANS may not believe

fibrosis of the sphincter of oddi is a true entity, Drs. Cole, Harridge and Roberts are thoroughly convinced that this syndrome is a valid one because they state that they have seen many patients with an opening in the duodenal papilla too small to accept even the tip of a small artery forceps.

The condition is most dramatically observed in patients who fail to have their R.U.Q. symptoms relieved by cholecystectomy. Symptoms cannot be differentiated from those induced by stones in the common duct.

They believe there is a definite indication for cutting the sphincter of oddi when stenosis is encountered.

Harridge, W. H., M.D.; Roberts, S. S.; and Cole, Warren H., M.D.: Sphincterotomy for Stenosis of the Sphincter of Oddi.

AMERICAN COLLEGE OF PHYSICIANS ANNOUNCES AWARD WINNERS

The American College of Physicians announced January 24, 1963, recipients of five awards to be presented during the 44th Annual Session of the College in Denver, Colorado, April 1 to 5.

The Board of Regents also voted to confer Honorary Fellowships on two distinguished physicians from outside the United States who are scheduled to address the Session.

Award Announcements

Dr. Franklin M. Hanger, Staunton, Virginia, President of the College, said the following awards will be made at Convocation ceremonies:

The John Phillips Memorial Award (for distinguished contributions to internal medicine) to John A. Leutcher, M.D., Palo Alto, California, Professor of Medicine, Stanford University School of Medicine.

Preventive Medicine

The James D. Bruce Memorial Award (for distinguished contributions in preventive medicine) to Charles H. Rammelkamp, Jr., M.D., F.A.C.P., Cleveland, Ohio, Professor of Medicine, Western Reserve University School of Medicine.

College of Physicians Award

The American College of Physicians Award (for distinguished contributions in science as related to medicine) to Arnold R. Rich, M.D., Baltimore, Maryland, Emeritus Professor Pathology, Johns Hopkins School of Medicine.

The Alfred Stengel Memorial Award (for outstanding

service to the American College of Physicians) to Walter L. Palmer, M.D., M.A.C.P., Chicago, Illinois, Professor of Medicine, University of Chicago School of Medicine.

Award for Non-Physician

The Edward R. Loveland Award (bestowed on a non-physician for distinguished contributions in the health field) to Robert Stearns, Ph.D., Denver, Colorado, former President of the University of Colorado and President of the Boettcher Foundation.

Honorary Fellowships

Honorary Fellowships in the American College of Physicians will be bestowed on Sir Macfarlane Burnet, O.M., F.R.S., Melbourne, Australia, Director of the Walter and Eliza Hall Institute and Professor of Experimental Medicine, University of Melbourne; and Fritz Koller, M.D., Basel, Switzerland, Professor of Medicine, University of Zurich.

Dr. Burnet will present the annual Lilly Lecture on "The Thymus and Auto-Immune Disease," and Dr. Koller will speak on "Clinical and Genetic Aspects of Coagulopathies."

Three medalists will give memorial lectures. Dr. Palmer will speak on "Corticotropin and Adrenal Steroids in Inflammatory Disease of the Digestive Tract;" Dr. Rammelkamp's paper will be on "The Transmission of Streptococcal and Staphylococcal Infections," and Dr. Leutscher's on "Observations on Metabolism of Aldosterone in Man."



THE ASSOCIATION

DEATHS

W. P. EZZARD, 83, a general practitioner in Forsyth County and Lawrenceville for almost 60 years, died recently in a private hospital.

A native of Forsyth County, Dr. Ezzard graduated from the Emory University School of Medicine. He was a member of the Lawrenceville First Methodist Church, the Medical Association of Georgia, the Gwinnett County Medical Society, and the Gwinnett County Board of Education, on which he had served for 20 years. Dr. Ezzard was an honorary member of the National Geriatrics Society, a former surgeon for the Seaboard Airline Railways, and a Mason.

He is survived by his wife, Jean McMillan Ezzard, Dacula; five daughters, Dorothy, Virginia, Mary, Martha, and Mrs. Davis Brand, all of Lawrenceville; a son, Dr. George P. Ezzard, Lawrenceville; a sister, Mrs. Maude Westbrook of Powder Springs; and a brother, H. H. Ezzard of Dalton.

JOYCE F. MIXON, SR., of Valdosta, died January 11, 1963, at the age of 83. A native of Gainesville, Florida, Dr. Mixon came to Valdosta in 1914 and continued to practice medicine until his death.

Survivors include his widow; two daughters, Mrs. J. Miller of Columbia, S. C.; Mrs. Robert Anderson of Valdosta; two sons, Dr. Joyce Mixon, Jr., and Dr. Harry Mixon, both of Valdosta; brothers, Dr. C. G. Mixon of Gainesville, Fla., and William T. Mixon, Coral Gables, Fla.; and a sister, Mrs. Georgia Jackson of Orlando, Fla.

JESSE L. MEEKS, Gainesville physician and civic leader, died January 7, 1963. Dr. Meeks was graduated from Emory University School of Medicine and interned at Battle Hill Sanatorium and Grady Memorial Hospital in Atlanta. He was a member of the AMA, the Medical Association of Georgia, and the Hall County Medical Society, for which he had served as president. Dr. Meeks also served as clinic physician at Gainesville Mills for a number of years. Civic activities included his membership in the Elks Club, Kiwanis Club, American Legion, Chatahoochee Country Club, and the First Methodist Church.

Survivors include his wife, Mrs. Ione Tumlin Meeks, Gainesville; one son, Dr. Littleton Meeks, Lexington, Mass.; two daughters, Miss Jean Meeks, St. Louis, Mo. and Miss Margie Meeks, Palo Alto, Calif.; three sisters, Mrs. L. W. Hook, Savannah, Mrs. Ben Pless, Cartersville; and Miss Lula Meeks, Atlanta. and three grandsons.

JOHN ASA FAULKNER, JR., Augusta, died at his home January 11, 1963. Dr. Faulkner was a member

of the Covenant Presbyterian Church, the Richmond County Medical Society, the Medical Association of Georgia, the Southern Medical Association and the Georgia Orthopedic Society.

Surviving are his wife, Alva H. Faulkner; two sons, John Michael and Robert Mark Faulkner and one daughter, Alice Lynne Faulkner, all of Augusta; three sisters, Mrs. Thelma Davis and Mrs. Fred Walker of Griffin, Ga., and Mrs. Charles Bennett of New York, N. Y.; one brother, Donald Faulkner of Ponchatoula, La., and a number of nieces and nephews.

HUGH EDWARD HAILEY, Atlanta dermatologist, was killed in an automobile accident January 14, 1963. Dr. Hailey was 53.

Graduated from Emory University School of Medicine, he interned at Grady Memorial Hospital and did postgraduate work at the Vanderbilt Clinic of the New York Skin and Cancer Hospital and the New York Hospital of Columbia University.

Dr. Hailey was a member of the Fulton County Medical Society, the AMA, the Medical Association of Georgia, the Piedmont Driving Club, Capital City Club, and the Nine O'Clocks.

Surviving are his wife, Claire Hunnicutt Hailey; a daughter, Claire Ridley Hailey; a son, Hugh E. Hailey, Jr.; and a brother, Howard Hailey, all of Atlanta.

SOCIETIES

The newly elected officers of the CAMDEN-CHARLTON MEDICAL SOCIETY were installed at the first annual meeting January 7, 1963, in St. Mary's. Those taking office were R. R. McCollum, president; G. W. Barker, vice-president, and H. H. Robinson, secretary-treasurer; J. M. Jackson and R. E. Stubbs were named as delegate and alternate to the MAG House of Delegates.

After a discussion of his attendance at the recent AMA Clinical Meeting in Los Angeles by Frank Robbins, the members were treated to dinner at the Crab Shell Restaurant by Dr. Stubbs.

Leonard C. Durrence, Blackshear, was named president of the WARE COUNTY MEDICAL SOCIETY at a recent meeting held in Waycross. Other officers elected were Wilbur L. Flesch, vice-president; S. William Clark, Jr., secretary-treasurer; W. L. Pomeroy and Floyd E. Davis, delegates; and W. B. Bates, Jr., alternate.

WHITEFIELD COUNTY MEDICAL SOCIETY met January 13, 1963, at Dalton. A Surgical-Pathological conference was presented by Evelyn M. Stephenson, pathologist, of Dalton; and David M. Nowell and Murray B. Lumpkin, Dalton.

PERSONALS

First District

HENRY DEJARNETTE, Vidalia physician, is currently serving as an instructor for a course in Medical Self Help Training being sponsored by the Civil Defense Department of Vidalia.

Formerly of St. Mary's, FRANK THAYER ROBBINS, has begun his practice in medicine and general surgery in Hinesville.

WILLIAM B. CRAWFORD, JR. is the new president of the medical and dental staff of St. Joseph's Hospital in Savannah. Other officers named at the annual staff meeting are CHARLES SAX, vice-president; ALEXANDER PADEREWSKI, treasurer; and J. REID BRODERICK, JR., secretary.

FREDERICK D. MANER was appointed chairman of the program committee.

The staff elected W. W. OSBORNE chief of the department of obstetrics and gynecology. Other department chiefs are WILLIAM H. LIPPITT, surgery; FENWICK NICHOLS, internal medicine; and Dr. Crawford, general practice.

JAMES F. GLENN, Durham, N. C., who will soon assume the duties of professor of urology at Duke University Medical School, spoke to the Savannah Surgical Society on January 23, 1963. Dr. Glenn spoke on "Surgical Hypertension." JAMES ALEXANDER, Savannah, is president of the society.

L. M. FREEDMAN was re-elected president of the Physicians Service Association of Savannah at the annual meeting of the association January 16, 1963.

GRANT W. GOLDENSTAR and DEARING A. NASH were elected directors for three-year terms. The following directors whose terms expired were re-elected to succeed themselves: LAURENCE B. DUNN and W. W. OSBORNE.

Second District

Guest speaker for the Sylvester Woman's Club at the January Meeting was GEORGE R. DILLINGER of Thomasville who spoke on "Medical Care for the Aged." Dr. Dillinger was introduced by H. G. DAVIS, JR., Sylvester.

Third District

No news submitted.

Fourth District

J. W. CHAMBERS, LaGrange, spoke to the LaGrange Lions Club January 15, 1963, concerning existing laws governing health care of the aged. Dr. Chambers is a member of the House of Delegates of the AMA.

Fifth District

"The Early Diagnosis and Treatment of Mental Illness" was the title of the talk given by ROBERT J. VAN DE WETERING, Atlanta, at the February 1, 1963, meeting of the Woman's Auxiliary, Fulton County Medical Society.

Atlanta radiologist, TED F. LEIGH, was a recent guest speaker at the Buffalo Radiological Society in Buffalo, N. Y., January 14, 1963.

Leaders in the project to organize and establish a North Side General Hospital to serve North Fulton and North DeKalb Counties in the greater Atlanta area are, HARRY ARNOLD, NORMAN BERRY, AMEY CHAPPELL, ROSS J. COX, HERBERT GIRARDEAU, JOHN M. McCOY, DONALD W. RAIRIGH, LOUIS RICCARDI, LEA RICHMOND, LEIGH SCOTT, HERBERT SHESSEL, CHARLES M. SILVERSTEIN, WARNER WOOD, and GRATTAN C. WOODSON.

Sixth District

JOHN A. BELL, JR., Dublin, president of the Seaboard Surgeons Association, recently returned from Hamlet, N. C., where he attended an annual safety awards meeting. Each year an award is given to the area having the minimum number of accidents; this year the recipient was Hamlet.

Seventh District

At the December 3, 1962, meeting of the Gordon County Hospital Medical Staff, WILLIAM R. THOMPSON, Calhoun, was elected to serve as president of the medical staff for 1963.

Other officers elected to serve with Dr. Thompson were: R. D. WALTER, vice president, and J. L. RABB, secretary.

THOMAS E. ADKINS, Rossville, has been elected chief of the medical staff of John L. Hutcheson Memorial Tri-County Hospital for 1963.

Serving with Dr. ADKINS are N. H. HUTCHISON, vice chief of staff; W. D. CRAWLEY, secretary; J. P. SIMS, chief of general practice; L. PERCY SHERRILL, chief of medical services; FRANK L. O'CONNOR, chief of surgical services; and F. JONES SMILEY, chief of obstetrical and gynecological services.

Eighth District

ISBEN GIDDENS of Lakeland moved into his new clinic the first part of January; it is located on West Main Street, Lakeland.

Ninth District

No news submitted.

Tenth District

JOHN T. MAULDIN, Atlanta, spoke to the Ladies Auxiliary of the Richmond County Medical Society at the January 22 meeting in Augusta. Dr. Mauldin spoke on the Kerr-Mills Program in Georgia. While in Augusta, Dr. Mauldin also spoke at an evening meeting of the Richmond County Medical Society.

ROBERT D. LANGE, associate professor of medicine at the Medical College of Georgia, Augusta, has recently been awarded a National Institute of Health Research grant in the amount of \$24,823 for the purpose of studying chemotherapy as a means of treating cancer.

PAUL D. WESTON, Augusta, has announced the resumption of his practice at his office at 1235 Gwinnett Street, Augusta.

EXECUTIVE COMMITTEE OF COUNCIL MEETING

THE REGULAR MONTHLY MEETING of the Executive Committee of Council of the Medical Association of Georgia was called to order by President Thomas W. Goodwin, at 2:45 P.M., on January 19, 1963, at the Holiday Inn, Pine Mountain, Georgia.

Those in attendance at the meeting were: Thomas W. Goodwin, Augusta; Fred H. Simonton, Chickamauga; John S. Atwater, Atlanta; George H. Alexander, Forsyth; J. G. McDaniel, Atlanta; John T. Mauldin, Atlanta; and George R. Dillinger, Thomasville. Mr. Richard Nelson, of the AMA Field Service Division was present, and representing the MAG staff were Mr. Milton D. Krueger, Mr. James Moffett and Mrs. Catherine Wooten.

Reading of the Minutes

The reading of the minutes was dispensed with as they had been distributed to the members prior to this meeting. On motion duly made and seconded it was voted to approve the minutes as published.

Georgia Tax Research Foundation Request

Mr. Krueger gave information regarding the Georgia Tax Research Foundation request for submission of two names of proposed trustees of GTRF from each Congressional District. These people should be leaders in their communities, either medical or lay leaders. On motion (Goodwin-McDaniel) it was voted that each District Councilor be contacted and asked to submit two names.

Steering Committee Recommendations on Mental Health Program

Mr. Krueger stated that an AMA letter had been received regarding an Annual Conference on Mental Health Representatives of State Medical Association to be held March 1 and 2, 1963, in Chicago. It was recommended that the Mental Health Sub-Committee decide whether or not a representative should be sent to this conference. If the Mental Health Sub-Committee decides that a representative should attend, the Chairman should request funds for attendance.

Mr. Krueger informed the Executive Committee that the present Chairman of the Mental Health Sub-Committee, Dr. Maurice Arnold, had tendered his resignation. President Goodwin suggested that a Mental Health Sub-Committee be appointed, with a new chairman, and to refer to them the recommendations made by the Steering Committee on the National Congress on Mental Illness held in Chicago in October 1962, for investigation, recommendation and report to Council. On motion (Goodwin-Alexander) it was voted to appoint a member from each Congressional District and to allow the Chairman to decide the staggered terms of office of each member. The following names were suggested and they will be asked to accept this appointment:

- 1st District: Abraham Center, Savannah
- 2nd District: W. V. Watt, Thomasville
- 3rd District: Frank A. Wilson, Leslie
- 4th District: Herbert D. Tyler, Thomaston
- 5th District: A. S. Yochem, Atlanta, Chairman
- 6th District: J. R. S. Mays, Macon
- 7th District: M. V. B. Teem, Marietta
- 8th District: Leo Smith, Waycross
- 9th District: P. K. Dixon, Gainesville
- 10th District: B. F. Moss, Augusta
- Ex-officio: Addison M. Duval, Atlanta

Laurens County Medical Society Problem

Mr. Krueger reported that the Blood Banks Sub-Committee had scheduled a meeting in February to study the problem previously presented to Council, and would make a report on their investigation as soon as possible after that time. This report was received for information.

AMA Medicolegal Symposium, March 8-9, 1963, Miami Beach

Mr. Krueger stated that the Executive Committee had been requested by Council to designate a representative from MAG to attend this Symposium. After discussion Dr. Charles S. Jones, Atlanta, was selected as the MAG representative, Dr. McDaniel was asked to call him regarding appointment as Chairman of the Medical Defense Committee, and to ask him to attend this meeting. Dr. Jones agreed to accept the appoint-

ment and to attend the Symposium. Dr. J. Frank Walker is to be on the program.

Physician's Widow's Request

A letter from Dr. Rudolph Bell was read regarding a doctor's widow who was in financial need. He had inquired if there were a fund for such purposes. It was suggested that the MAG Insurance and Economics Board be asked to study this and make recommendations. On motion (Goodwin-Alexander) the above suggestion was approved. The Secretary was instructed to write Dr. Bell that no such funds were available but that the matter was being referred to the Insurance and Economics Board for study.

U.S. Commission on Civil Rights Request

President Goodwin stated that the Civil Rights Commission had requested a copy of the brief filed in the Civil Rights case. The Medical Association of Georgia, with the Association's attorney's advice, complied with this request. This report was received for information.

Medicare Contract with Suggested Change Approval

President Goodwin stated that the change requested by Dr. Joseph B. Mercer at the December Council meeting had been approved by the Washington Office of Medicare, and had been included in the contract, therefore, the contract was ready for signature.

Appointment to Interprofessional Council

Mr. Moffett informed the Executive Committee that Dr. A. H. Letton had tendered his resignation on the Interprofessional Council, and that another representative of MAG would have to be appointed. On motion duly made and seconded it was voted to appoint C. Daniel Cabaniss, Atlanta, to the Interprofessional Council.

Tenth Street Business Assessment

President Goodwin stated that in addition to the dues of \$30.00 an additional assessment of \$10.00 had been requested. He asked the Executive Committee their opinion as to whether the Association should continue membership in this organization. After discussion it was suggested that the Secretary investigate the benefits derived from membership in the organization and report back to the Executive Committee.

Headquarters Office Report

Mr. Krueger brought the following items of business to the Executive Committee:

(1) Purchase of Coke Machine: With increased use of the Headquarters building the need for more cokes has become apparent, and after discussion on motion duly made and seconded it was voted to approve the purchase of a coke machine with Dr. Atwater and Dr. Mauldin to investigate the best plan of purchase.

(2) Use of MAG Building: Mr. Krueger reported that various groups have decided to use the building for meetings. After discussion it was decided that only civic or allied health groups could use the building.

New Business

(1) State Board of Workmen's Compensation Medical Board Appointments: Due to illness Dr. Albert Rayle, radiologist, has resigned from the Board; and the untimely death of Dr. Hugh Hailey, dermatologist, has necessitated his replacement. Therefore two names in each specialty were suggested: Radiology: J. Frank Walker, Atlanta; and W. C. Coles, Atlanta. Dermatology: David L. Hearin, Atlanta; and Herbert S. Alden, Atlanta. Governor Sanders is to be given the above names for his consideration.

(2) Dr. Walter Bloom, Chairman of Sub-Committee on Medical Education, has requested funds for attending an AMA Council on Medical Education meeting, which he failed to ask for in a budget request. On motion duly made and seconded it was voted to authorize \$200.00 to be taken from the Contingent Fund.

(3) Lundell Letter: After reading Dr. Lundell's letter to the Executive Committee the Secretary was instructed to write Dr. Lundell that unless he is a member of the Camden-Charlton County Medical Society, the Waycross Memorial Hospital cannot consider his application for staff privileges.

THE ASSOCIATION / Continued

Legal Status of Nurse as First Assistant in Surgery

Dr. Mauldin read a letter from a physician, requesting the legal status of a nurse as first assistant in surgery. After discussion about usual practice in the majority of communities in Georgia, it was recommended that the doctor be written that this should be established locally when the question arises, depending upon the general feeling of the surgeons in that area.

Columbus Blue Shield Resolution on Podiatry

Dr. Mauldin reminded the Executive Committee that this resolution had been submitted at the December Council meeting and referred to the Executive Committee for advisement and report back to Council. After discussion, it was decided to take no action on the resolution and to receive this report for information.

Medicare Claims

Three Medicare claims were submitted for review. It was the opinion of the Executive Committee that the three physicians whose claims were to be reviewed, should be asked to attend the February Executive Committee meeting to discuss their indi-

vidual claims. The Medicare Administrator is to be instructed to write the physicians to this effect.

State Department of Public Health Meeting Report

Dr. Simonton stated that the "Family Responsibility Proposal" was written into the codification of public health laws verbatim as submitted by the Medical Association of Georgia. He also read the other changes in the laws in which the Association was interested and had made suggestions for change. All of the four suggested changes, as stipulated in previous minutes, had been approved and were incorporated in the public health laws.

Timer for Parking Lot Light on Headquarters Building

Mr. Krueger presented the problem of lighting the parking area at night when meetings are held in the Headquarters Building. On motion duly made and seconded it was voted to purchase an automatic timer for the parking lot light.

Date and Site of February Meeting

By mutual agreement it was decided to hold the meeting on February 17, 1963, at 10:00 A.M., MAG Headquarters, Atlanta.

There being no further business the meeting was adjourned at 5:30 P.M.

EXTENT OF PROFESSIONAL LIABILITY INSURANCE COVERAGE

The Council of the Medical Association of Georgia received several inquiries from MAG members concerning the extent of professional liability coverage under the St. Paul Insurance Company's policy. Specifically, the queries posed the question of coverage of a physician's acts or omissions while serving as an officer, committee or board member of any organized medical group. It was noted that other professional liability insurance policies carried the clause, "Acts or omissions of the insured as a member of a formal accreditation or similar professional board or committee of a hospital or professional society, committed during the coverage period in the practice of the Insured's profession described in the declaration, shall be covered."

The Association directed an inquiry on this matter to the St. Paul Companies to ascertain the extent of St. Paul coverage on this item as the St. Paul Company does not make a specific declaration in their policy on this matter. MAG is pleased to cite the St. Paul Company's reply which clearly indicates this specific protection is afforded by St. Paul as follows:

"The Medical Association of Georgia letter of December 17, 1962, cites wording from another policy concerning coverage for acts or omissions of a doctor as a member of a formal accreditation or similar professional board or committee of a hospital or professional society. This phraseology was initially approved by the National Bureau of Casualty Underwriters on November 29, 1961.

"The St. Paul Fire and Marine Insurance Company has always recognized claims under our policy arising from such circumstances. Some professional liability policies are more limited in phraseology and for that reason apparently it was necessary to specifically spell out the clause in question. Our form because of its comprehensive insuring clause would provide coverage for these activities of a doctor. The comprehensive insuring clause of the MAG-St. Paul sponsored policy makes it unnecessary to specifically endorse the policy with the phraseology in question."

CANCER COMMITTEE ANNOUNCES PRESENTATIONS

The Cancer Teaching Committee of the Medical College of Georgia announces the following lectures and clinical presentations as part of the Cancer Teaching Program for 1962-1963.

PATHOLOGICAL PHYSIOLOGY OF THE HUMAN TUMOR BEARING HOST

- 26 March, 1963—Surgery Cancer Conference, Dr. Harold S. Engler, Associate Professor of Surgery, Medical College of Georgia, presiding.
- 11 April, 1963—Medicine Cancer Conference, Dr. Robert Lange, Associate Professor of Medicine, Medical College of Georgia, presiding.
- 23 April, 1963—Dr. J. A. Del Regato, Director, The Penrose Cancer Hospital, Colorado Springs, Colorado.

COMPATIBILITIES AND INCOMPATIBILITIES OF RADIATION THERAPY AND SURGERY

- 9 May, 1963—Dr. S. O. Schwartz, Director, Department of Hematology, The Hektoen Institute of Medical Research at the Cook County Hospital, Chicago, Illinois.

VIRUS ETIOLOGY OF CANCER

Physicians and medical students are cordially invited to attend these presentations concerning the field of neoplasia. Each of the out-of-town visitors will spend a few days at the Medical College of Georgia and anyone desiring to discuss problems with them should make an appointment with the Chairman of the Cancer Teaching Committee, Dr. H. J. Peters, Medical College of Georgia.

The lectures and clinical demonstrations will be held at 12 noon in the large auditorium of the educational building of the Medical College of Georgia.

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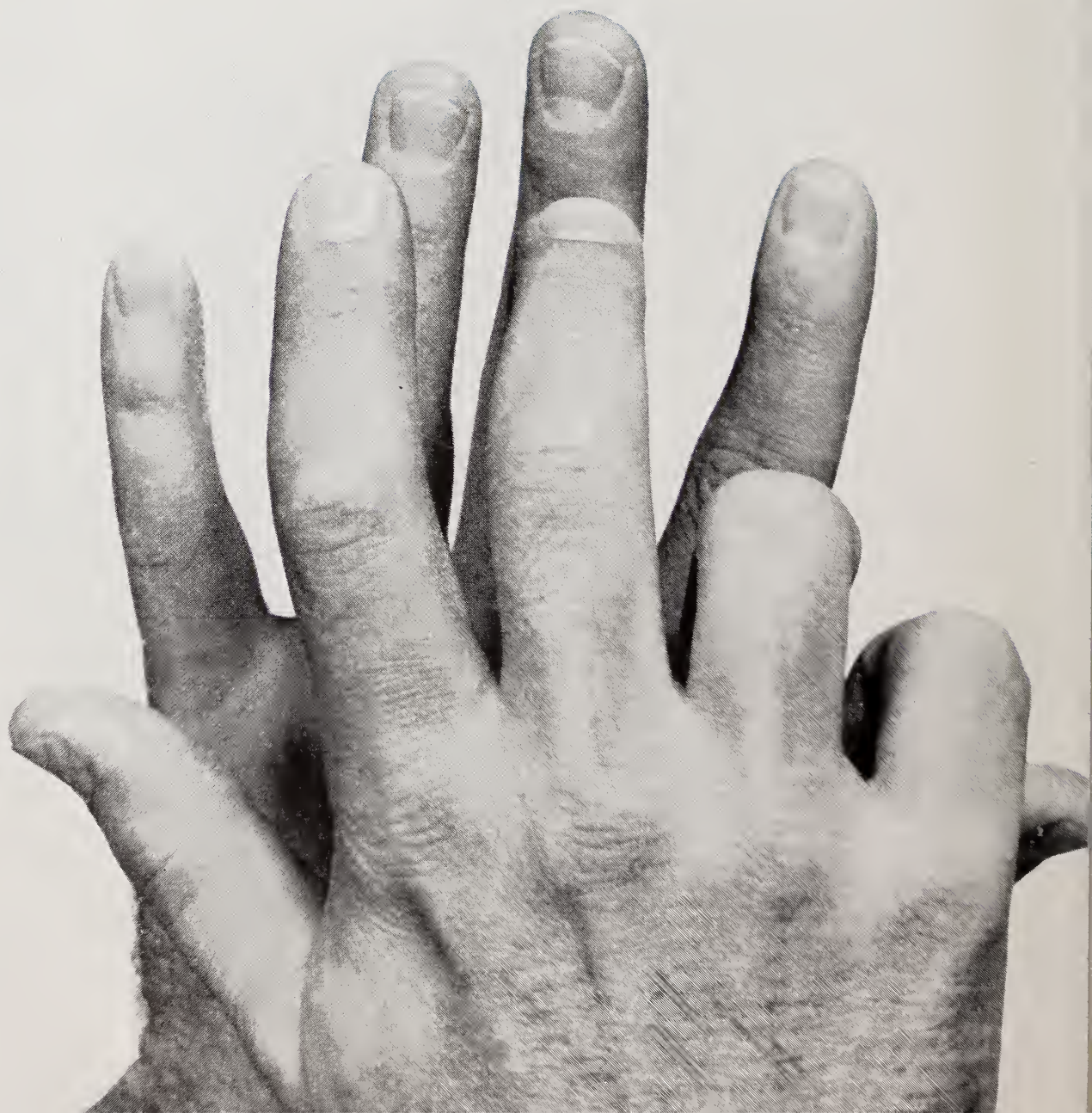
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Contents

Scientific Articles

- CARCINOMA OF THE TONGUE, REPORT OF A GROUP OF PATIENTS
S. Angier Wills, M.D. 157
- STRAW ITCH MITE DERMATITIS CAUSED BY PYEMOTES VENTRICOSUS
Robert M. Fine, M.D., and Harold George Scott, Ph.D. 162
- CARPHENAZINE IN THE WITHDRAWAL PHASE OF ACUTE ALCOHOLISM
Vernelle Fox, M.D. 167
- RECOGNITION OF THORACIC SURGICAL EMERGENCIES IN INFANTS
William E. Laupus, M.D., and Robert G. Ellison, M.D. 171
- BONE DISEASE OF RENAL ORIGIN
Gordon C. Miller, Senior Medical Student 174
- USE OF MAGNETIC FORCE IN REMOVING A METALLIC FOREIGN BODY
W. C. Tippins, Jr., M.D. 177

Editorials

- GASTRIC FREEZING, NEW TREATMENT FOR PEPTIC ULCER DIATHESIS 179
- MAA EXPANSION OF GEORGIA KERR-MILLS 180
- DIAGNOSTIC RADIATION AND EARLY PREGNANCY 181

Features

- How Well Are We Telling Our Story? 170
- President's Letter 183
- Cancer Page 184
- Heart Page 186
- Mental Health Page 188
- Physician's Bookshelf 190
- Abstracts 192

The Association

- Deaths 194
- Societies 194
- Personals 195
- Executive Committee of Council Meeting, February 17 196
- Sub-Committee on Blood Banks, February 20 198
- Medical Education Board Meeting, February 24 198
- Advertising Index 48A

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CARCINOMA OF THE TONGUE

Report of a Group of Patients

S. Angier Wills, M.D., *Atlanta*

- ***The presence or absence of cervical node metastases is the most reliable feature for clinical prognostication.***

THIS REPORT CONCERNS a group of patients with carcinoma of the tongue treated at Grady Memorial Hospital during the years from 1949 to 1960.

Survival percentages for squamous cell carcinoma of the tongue may vary among different reports, but one factor seems to be common to all series; there is a much higher survival rate in those patients in which there are no cervical node metastases. Another aspect of squamous cell carcinoma of the tongue is the high incidence of cervical node metastases found in these patients. Some reports state that 40 per cent of the patients will have cervical node metastases when first seen and that 70 per cent of these patients will eventually develop nodal metastases. If there is a history of one year duration of the lesion, then 90 per cent of those patients will have cervical node metastases. If the lesion is four cm. in size, then 90 per cent of these patients can be expected to have cervical node metastases; whereas, with lesions of one cm. size, the expected incidence of cervical node metastases is only 20 per cent.^{2,5,10} This report serves to emphasize these two aspects of the disease.

Metastases in the Neck

Other authors have emphasized, as we wish to re-emphasize, that when dealing with a squamous cell lesion of the tongue one must suspect lymph node metastases in the neck. The metastatic deposits from carcinoma of the tongue tend to involve many nodes giving rise to small degrees of lymphadenopathy rather than to a few large metastases. Also bilateral

cervical metastases is a rather common occurrence (an incidence of six per cent, or if the lesion encroaches near the midline an incidence of 32 per cent.)¹⁰ While it is true that small primary lesions of the tongue are less likely to metastasize, some of the smaller lesions will have lymphnode metastasis. It is quite difficult to tell which ones have node involvement at the time the patient is first seen. Since so many of the patients do develop metastatic disease early in the life history of the tumor and even the small lesion may behave in a very virulent manner, it would be best to strongly consider neck dissection in those patients with carcinoma of the tongue at the time of their primary surgery.^{8,2,9,10}

Radiation Alternative

While radiation therapy is an alternative form of treatment^{1,4} for some of the early lesions of carcinoma of the tongue, the complications of such therapy, the length of time involved, and the discomfort is greater than with surgical removal. Also, surgery seems to offer the patient with carcinoma of the tongue a better chance of five year survival.^{4,5,6,7} Certainly this is true in patients who have cervical node metastases, and for lesions larger than two or three centimeters. Proponents of radio-therapy admit that comparable results to surgery can only be obtained by interstitial radio-therapy and that cervical metastases can only be palliated with radiation treatment.¹ They agree that cervical node metastases can best be managed surgically. In a disease that is frequently associated with cervical metastasis early in its evolution, it is best to plan therapy along those lines that

will take care of both the primary disease and the secondary metastasis.

The wisdom of this is borne out by those authors who report a much higher survival rate in their patients with positive nodes for which prophylactic neck dissection has been done in contrast to those surgeons who do neck dissections only when cervical nodes are palpable.⁶ The question can thus be settled when one demonstrates that the primary lesion can be controlled in the majority of incidences, as it seems to be in 40-50 per cent; that the operative mortality is in acceptable limits and that the salvage rate is higher in those patients with prophylactic neck dissection and positive nodes than in those patients who have later therapeutic dissections for positive nodes.

Better Prognoses

Other authors point out the better prognosis for the lesions less than one cm. in size^{3,10,5} also a better prognosis for carcinoma of the anterior portion of the tongue rather than the base of the tongue (pharyngeal tongue). The most striking difference in survival rates, however, are in those patients without cervical node metastases in which a five-year survival rate of approximately 45 to 55 per cent is reported; whereas, in patients with cervical node metastases approximately ten per cent survive five years. An over-all survival rate of 20 to 35 per cent is the average reported. The patient who has a small lesion on the anterior tongue not associated with cervical metastasis has the best chance of five-year survival.

Case Material

Forty-three patients with carcinoma of the tongue were seen between the years 1949 and 1960. There were 26 male and 17 female patients. Twenty-eight (65%) of these patients were in the sixth and seventh decades. Another six (14%) were in the eighth decade. There were three (7%) patients in the ninth decade and four in the fifth decade (Figure 1).

FIGURE 1

Age Decades:		3rd	4th	5th	6th	7th	8th	9th
		1	1	4	15	13	6	3
Sex:	Male	26						
	Female	17						
Total patients:		43						
Treatment:								
	Surgery	35	Combined procedure		25			
	X-Ray	6	Partial glossectomy		10			
	None	2	Post-op deaths		3 (8.6%)			

Thus, it seems that the sixth and seventh decades are the prime ones for the highest incidence of squamous cell carcinoma of the tongue. In this series the lesion of those patients in the younger generations was associated with a different historical or patho-

logical setting. One patient in the third decade had a Mucoepidermoid Carcinoma and has now been living two years without recurrence of disease after resection. One other patient who was in the fourth decade was a heavy smoker and had a long history of alcoholic intake associated with DT's on several occasions. Most of these patients smoked one to two

FIGURE 2

Duration Symptoms Prior to Treatment

	No. of Positive Patients Nodes		Survival	
1 month	5	1	2 yrs. NED 3 yrs. NED 4 yrs. DIED	5 yrs. NED 1 yr. DIED
2 months	8	8	3 yrs. NED + Nodes	
3 months	5	4	1 yr. NED — 0 Nodes	
4 months	2	1	6 yrs. NED — 0 Nodes	
5 months	8	4	4 yrs. NED 3 yrs. NED	6 yrs. NED all with 9 yrs. NED 0 Nodes
9 months	4	1	1 yr. NED 2 yrs. NED 10 yrs. NED	all neg. Nodes
10 months	3	3	11 yrs. NED + Nodes	
1 year	3	3	7 yrs. NED + Nodes 3 yrs. NED	(Laryngectomy)
1½ years	2	2	0	
3 years	1	0	2 yrs. NED — 0 Nodes	
No. Rx Group	2	—		
Total	43	27—(63%)		

packages of cigarettes a day or were users of snuff. Many of them had areas of leucoplakia about the oral cavity.

The average duration of symptoms prior to therapy was approximately four months. Twenty of the 43 patients gave a history of four months or less duration. The initial symptom was usually soreness of the tongue and only an occasional patient complained of a lump rather than pain (Figure 2). The lesion varied from an almost invisible excoriation of the malignant area of the tongue associated with some palpable induration, to that of frank ulceration or exfoliation of the tumor. In several incidences it was demonstrated that palpation was as necessary as visual inspection in order to find the area of abnormality.

Incidence of Cervical Metastases

Twenty-seven out of the 43, or almost 63 per cent of these patients, were found to have positive nodes at the time of their initial treatment (Figure 3). Positive cervical nodes were found in those patients with a history of a lesion or pain for one, two, three, four or five months duration. There seemed to be little difference in the incidence of positive nodes in those lesions with a history of two or more months duration. However, in five patients who had symptoms of only one month duration, only one was found to have positive cervical nodes. Three of these five patients are living; two, three and five years after therapy. One other patient who lived four years after

surgery died and no autopsy was obtained. Thus, four out of five of these patients with a one month history of symptoms had a much better survival rate than was found in the rest of the group.

Statistics

There were 14 patients (34%) in whom no metastatic disease was found in the cervical nodes at the time of primary treatment. Eighty-five per cent of these were alive at the end of two years and 50 per cent were alive at the end of three years. Six (43%) of these patients lived five, six, six, nine, ten and 26 years respectively. The patient who lived 26 years had three local recurrences successively treated by surgical resections. In contrast, in the group of patients with positive cervical nodes, 77 per cent were dead at the end of one year. Two patients (7.4%) lived four years, one lived seven years and one lived 11 years after treatment.

Fifty-three per cent of the patients, in the entire group, died within one year of the onset of their disease.

Thirty-five of these patients were treated surgically and six received X-ray therapy either for an attempted palliation or for attempted cure. There were three operative deaths; a surgical mortality of eight and one-half per cent. The usual surgical procedure was that of partial glossectomy, the extent determined by the tumor; or resection of the tongue, floor of the mouth and mandible as indicated by extension of the

FIGURE 3

Total No.: 41 Patients

14 pts. — 34%		27 pts. — 66%
Negative Cervical Nodes		Positive Cervical Nodes
6 months		
Alive	14	13
Dead	0	14
1 year		
Alive	1 — 13 still living	6
Dead	1	21 — 47%
2 years		
Alive	3 — 12 (85%)	4
Dead	0	23
3 years		
Alive	2 — 9 (64%)	4 — (14.8%)
Dead	0	23
4 years		
Alive	1 — 7 (50%)	2
Dead	1	25
5 years		
Alive	0 — 5 (35%)	2 (7.4%)
Dead	1	25
6 years		
Alive	2 — 5	2 (one 7 yrs. and
Dead	0	25 one 11 yrs.)
9 years		
Alive	1 — 3	
Dead	0	
10 years		
Alive	1 — 2	
Dead	0	
26 years		
Alive	1 — 1	
Dead	0	

FIGURE 4

Results of secondary neck dissection after partial glossectomy

No. patients 10

Cx Nodes developed in 7 No nodes developed 1 alive 3 yrs.
in 3 pts. 1 alive 6 yrs.
all 1 ° lesion / 2.5 cm. 1 alive 9 yrs.

Survival:

Time Recurrence After Glossectomy	Results
1 month	Dead in 1 year
3 months	Alive 2 years
3 months	Dead in 6 months
3 months	Dead in 9 months
3 months	Dead in 1 year
6 months	Dead in 8 months
8 months	Dead in 6 years with recurrent Oral Ca

One salvaged for 6 years and one alive after 2 years

local disease process. This was done in continuity with neck dissection if palpable nodes were present at the time the patient was seen. Two patients with rather extensive disease also had a laryngectomy at the time of the combined procedure.

Secondary Neck Dissections

There were ten patients treated by partial glossectomy. Positive cervical nodes developed in seven (70%) of these patients (Figure 4). These were treated by neck dissection. Over one-half of these patients developed palpable nodes within three months of their initial surgery. Only one was salvaged for six years and one is now living two years after neck dissection. It is interesting to note that the one that lived six years did not develop cervical nodes until eight months after his primary surgery, which is approximately three times the average time of cervical node development in the other patients.

The other three patients treated by partial glossectomy are alive and free of disease; one, six, and nine years after surgery. All three of these patients had primary lesions that were less than 2.5 cm. in diameter.

Local Recurrences

Local recurrences developed in nine patients (25%) (Figure 5). Seven of these occurred within a period of three to six months. Three of the nine patients were salvaged by re-excision. One is living without evidence of disease for one year, and one is living without evidence of disease for three years. The third patient had a recurrence of disease after 12 months and was salvaged by combined resection of the mandible and neck dissection. He is living without evidence of disease after seven years. The other six patients succumbed to their disease. Thus,

FIGURE 5

Local recurrence treated surgically:

9 pts. — seven recurrences within 3-6 mos.

Salvage: 3 patients

1 alive @ 1 yr.

1 alive @ 3 yrs.

1 alive @ 7 yrs.

three of the nine patients who had local recurrences were salvaged by further attempts at surgical resection.

Discussion

There were several interesting behavior qualities seen in this group of patients. One patient had a resection of the lesion of the tongue with neck dissection of a pull-through procedure thus saving the mandible. The pathologist reported tumor at the edge of resection and also peri-neural invasion. After no further treatment this patient is alive and without evidence of disease at the end of four years. Another patient had a combined tongue, mandible and neck dissection with laryngectomy. The margins were thought to be involved with tumor. This patient is alive without evidence of disease at the end of two years. One other patient reported as having margins not clear died of recurrent disease in six months.

Many Patterns in Series

One patient, one year after surgery with no evidence of local disease, died and was found at autopsy to have widespread carcinomatosis with metastatic carcinoma in the myocardium.

One patient had three local recurrences successfully treated by three surgical resections over a twenty-six year period.

Thus, many patterns of behavior are represented in this small series. It is difficult to predict which patient will have the best prognosis. Two features seem to be associated with a good prognosis: lesions of short duration, that is one month or less; and those associated with no cervical lymph node metastasis.

This wide spectrum of behavior probably reflects not only differences in the natural biologic evolution of the disease process but also differences in those factors that may function as resistant phenomena on the part of the host. The absence or presence of nodal metastasis probably reflects both of these relationships and is the most reliable feature for clinical prognostication.

Neck Dissection Logical

The high incidence of cervical node metastasis as seen in this series (63%) as has been reported in other groups, makes the consideration of neck dissection at the time of primary treatment appear logical. This combined procedure may not be necessary for small lesions located on the anterior one-third of the tongue, but from this study it is not possible to state whether there was any difference in nodal involvement with such lesions or not.

The results in these patients compare favorably with other reported series. However, they tend to emphasize strongly the frequency of cervical node metastasis and its dire prognostic consequences. They suggest that ipsilateral neck dissection should be a part of the initial surgical attack on carcinoma of the tongue except in those instances when the lesion is less than two centimeters in diameter, on the mobile portion of the tongue and of less than one month duration.

This study is not large enough to make dogmatic statements about this consideration but indicated that prophylactic neck dissection has a chance of increasing the five-year survival rate.

FIGURE 6
SUMMARY

Number of patients:	43
Duration of Sx:	4 months
Initial Sx:	80% pain
Positive node (Clinically evident)	
Initial:	20
Secondary:	7
	27 — (63%)
Local recurrences:	9 (25%)
5 yr. salvage:	3 (33%)
5 yr. salvage:	
Positive nodes	= 2:27 pts. (7.4%)
Negative nodes	= 6:14 pts. (43%)
Subsequent + nodes	= 1:7 pts. (14%)
Rx of Neck Dissection	

A group of 43 patients with carcinoma of the tongue has been presented (Figure 6). Marked differences in behavior patterns are demonstrated in this small group. The fatal outcome of this disease even with a history of short duration and particularly in those patients who have cervical lymph node metastases is pointed out. In those patients with no cervical lymph node metastases a two-year survival rate of 85 per cent, a three-year survival rate of 50 per cent and a five-year survival rate of 43 per cent was obtained.

Seventy-seven per cent of those patients with cervical node metastasis were dead at the end of the first year.

Sixty-three per cent of these patients were found to have positive cervical nodes at the time of their initial treatment. Seven out of ten (70%) of the patients treated without primary neck dissection developed positive nodes in the postoperative period. Only one (10%) was salvaged by secondary neck dissection.

It is probable that a greater number of people can be salvaged if they are seen as early as possible in the natural evolution of the disease and are treated vigorously in the manner that will give the best possible assurance of complete removal of the primary disease and its possible routes of metastasis.

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1963 ATLANTA GRADUATE MEDICAL ASSEMBLY DEEMED SUCCESS

The Twentieth Anniversary Session of the Atlanta Graduate Medical Assembly was held February 17 through 20 at the Atlanta Biltmore Hotel. At the Opening Session on Monday morning, addresses of welcome were given by Dr. Ted F. Leigh, Chairman of the Assembly; Dr. Thomas W. Goodwin, President of the Medical Association of Georgia; Dr. R. Carter Davis, President of the Fulton County Medical Society; Dr. Arthur P. Richardson, Dean of the Emory University School of Medicine; Dr. Robert I. Gibbs, President of the DeKalb County Medical Society; and Dr. Noah S. Meadows, President of the Cobb County Medical Society.

Ten States Represented

In spite of the epidemic of influenza, there was a total registration of 1,711, with the physicians numbering 1,027 of this total. It is interesting to note that there were 103 physicians from throughout Georgia in attendance (other than the membership of the Fulton County Medical Society). Other states represented were Alabama, Florida, Tennessee, Ohio, South Carolina, North Carolina, Texas, Kentucky, and Mississippi.

The faculty of 15 speakers were outstanding and each man made a valuable contribution to the meeting in the lectures presented and topics discussed at the seminars.

In Anesthesiology there was Dr. Nicholas M. Greene, of New Haven; in Cardiology the well-known Dr. Paul Dudley White of Boston; in Dermatology Dr. Edward P. Cawley of Charlottesville, Virginia; in Endocrinology Dr. Richmond W. Smith, Jr. of the Henry Ford Hospital in Detroit. Representing the fields of Obstetrics and Gynecology were Doctors Sprague H. Gardiner of Indianapolis and Robert W. Kistner of Brookline, Mass. Dr. J. Lawton Smith of the University of Miami School of Medicine delivered three lectures to the Ophthalmologists in attendance. In Orthopedics Dr. Harold A. Soffield of Oak Park, Illinois, gave lectures on topics of interest to the Pediatricians as well as the Orthopedists. From Canada Senator Joseph A. Sullivan of Toronto (his patients call him "Doctor", his friends call him "Senator") spoke on "The Alternative to State Medicine" and also gave two papers to the Otolaryngologists.

In Pathology Dr. James B. Arey of Temple University School of Medicine in Philadelphia delivered four lectures to the Assembly. Dr. Angela M. DiGeorge, also of Philadelphia, presented three papers of interest to the Pediatricians in attendance. In the field of Psychiatry we were honored to have Dr. Edward M. Litin of the Mayo Clinic, who came as a last minute substitute for Dr. Howard P. Rome, whose illness prevented his appearing on the program. Dr. William B. Seaman of Columbia University in New York brought lectures in the field of Radiology and participated in two round table seminars which were overwhelmingly received. In the field of Surgery the well-known Dr. Kenneth W. Warren of Lahey Clinic gave outstanding lectures to the group. Dr. Robert S. Hotchkiss of New York University was well received in his lectures to the Urologists.

There were eighty technical exhibits, representing every phase of the medical field insofar as drugs and equipment were concerned. There were three scientific exhibits, among these one sponsored by the Georgia AMPAC Group.

The Hospitality Lounge, sponsored by Wm. H. Rorer, Inc. was a highlight of the meeting and was efficiently and attractively staffed by members of the Woman's Auxiliary to the Fulton County Medical Society. The Ladies also handled the Paging Desk and the Ladies Registration. A coffee for the visiting ladies was held at the home of Dr. and Mrs. David Henry Poer, 3391 Tuxedo Road, N.W., on Tuesday of the meeting.

Specialties Sponsor Luncheons

Luncheons sponsored by the Specialty Groups were a part of each day's program and were well attended. On Wednesday there was a luncheon sponsored by the Georgia Heart Association, with 125 in attendance. Dr. William B. Fackler of LaGrange presided over this luncheon, with Dr. Paul Dudley White, the speaker, being introduced by Dr. J. Willis Hurst.

The Executive Committee is well pleased with the 1963 meeting, and is already working toward making the 1964 Atlanta Graduate Medical Assembly the most successful in its history.

STRAW ITCH MITE DERMATITIS CAUSED BY PYEMOTES VENTRICOSUS

Robert M. Fine, M.D., and Harold George Scott, Ph.D., *Decatur*

■ *The typical lesion is an urticarial papule surmounted by a pinhead sized vesicle.*

THE CAUSE OF STRAW ITCH was discovered in 1909 by Ducrey⁵ in Italy, and independently by Rawles¹¹ in Indiana. The first comprehensive investigation of the disease was by Goldberger and Schamberg^{6,7,13} who experimentally demonstrated the straw itch mite, *Pyemotes ventricosus* (Newport), (Figure 6) as the cause of straw itch. While most outbreaks have been associated with straw, cases have also been reported from a variety of other sources (Table 1). *Pyemotes ventricosus* has also been reported causing bronchial asthma.¹

Numerous names have been applied to this condition: Straw itch, grain itch, hay itch, dermatitis ditropenotus aureoviridis, acarodermatitis urticarioides, and others. Of the two most commonly used terms, straw itch is preferable to grain itch since human cases are usually associated with straw rather than with kernels of grain.

The purpose of reporting this outbreak is to draw attention to a previously unsuspected reservoir of this ubiquitous parasite, and to relate how fortuitous circumstances resulted in typical cases of this eruption. Attention is also called to this unusual source of mites so that in unexplained cases of generalized bites this possibility may be explored. Probably many cases of straw itch occur each year which are not diagnosed clinically or epidemiologically because of difficulty in finding the almost microscopic mite in the environment, and because the mite resides on the patient only briefly.

A 56-year-old housewife from DeKalb County,

Georgia (a patient of Dr. Virginia Tuggle), was seen in consultation for the first time in June 1961, complaining of a widespread pruritic eruption of about five weeks duration. On examination she had a large number of small, intensely pruritic, discrete, erythematous, urticarial papules distributed over the back, upper thighs, buttocks, and neck. The distal extremities, palms, soles, and mucous membranes were spared (Figure 3). Each papule was capped by a tiny vesicle or had a hemorrhagic punctum centrally. As these receded, ecchymoses and brownish pigmentation remained (Figures 1 and 2).

The patient is an asthmatic and has been taking five mgm. prednisone per day for a number of years. She also takes an occasional aspirin, but otherwise the drug history is negative.

The patient's husband and daughter each had one or two similar lesions.

There was no past medical history of significance. Complete blood count was normal with one per cent eosinophilia. Urinalysis was normal.

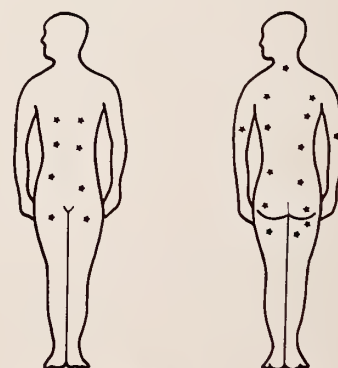


Figure 3

Distribution of *Pyemotes* bites on patient. Face and distal extremities were spared.

Dr. Fine is an instructor in Dermatology, Emory University School of Medicine and a practicing Dermatologist in Decatur, Georgia. Dr. Scott is an entomologist with Training Branch, Communicable, Disease Center, Public Health Service, U. S. Department of Health, Education, and Welfare, Atlanta, Georgia.



Figure 1

Distant view, *Pyemotes* bites on patient. Note sharp localization of bites on the trunk with some tendency to grouping.

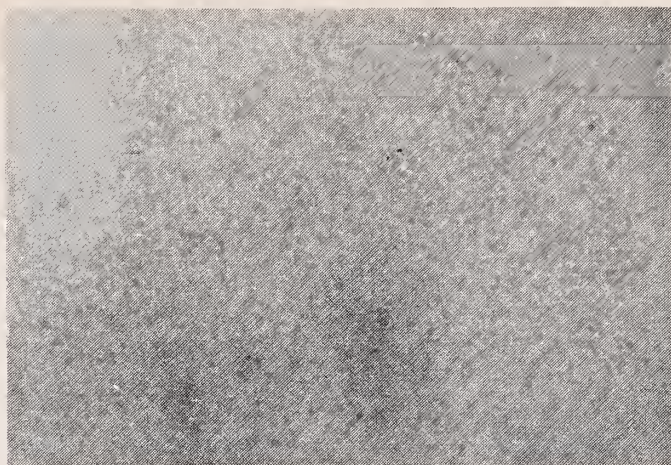


Figure 2

Closeup, *Pyemotes* bites on patient. Note punctum, hemorrhage and vascular response.

The clinical impression was multiple bites. On careful questioning, no source of exposure could be ascertained, and the patient (who once had done ectoparasite surveys) insisted that she had searched carefully and unsuccessfully for "vermin" in and around her house. She had sprayed her house and dusted her cat repeatedly. She kept no birds in the house, but did admit feeding birds in the back yard at close range.

Hexachlorocyclohexane lotion, diphenhydramine, and a cortico-steroid spray (triamcinolone aerosol) gave some relief from symptoms but new lesions continued to develop.

After the patient was informed that she was being bitten, she was able to locate tiny scurrying mites on her bedroom floor by using a magnifying glass while crawling around on her hands and knees. It was later learned that the patient had the habit of lying on the bedroom floor to relax and this is probably when she was bitten.

The mite was identified as *Pyemotes ventricosus*, the straw itch mite.

The type of patient cooperation reported here is exceptional and cannot generally be expected. It is,

therefore, necessary to increase the index of suspicion in cases of suspected bites and to direct the patient's search for the culprit.

The patient's asthma is not believed to be associated with *Pyemotes* since it predated the bites by such a long period of time.

The entomologist, while investigating the outbreak, was bitten as indicated in Figure 4. His reaction to the bites did not attain the degree noted on the patient but he experienced intense itching which was more pronounced in the later bites (Figure 5).

Goldberger and Schamberg^{6,7,13} report the time between bite and reaction to be 16 hours while Booth and Jones⁴ report 10-16 hours. This compares with the 17-28 hour times shown in Figure 5 which indicate the period from exposure to reaction rather than from bite to reaction.

Another attack of bites associated with this mite occurred in May 1962 with the patient again exhibiting most of the bites, but with numerous bites occurring on the daughter and a few on the husband.

The typical lesion resulting from the bite of *Pyemotes ventricosus* is an urticarial papule sur-

TABLE 1. SELECTED OUTBREAKS OF PYEMOTES VENTRICOSUS DERMATITIS IN MAN

DATE	PLACE	REPORTED HUMAN CASES	ASSOCIATED WITH	INSECT HOST	REFERENCES
1831-44	Massachusetts	numerous	straw beds	<i>Harmolita hordei</i>	8*
1908	Italy	numerous	?	?	5**
1909-10	Indiana	a number	wheat straw	<i>Harmolita tritici</i>	10, 11
	Pennsylvania, New Jersey	123 +	straw mattress	<i>Sitotroga cerealella</i>	6, 7, 13
1910	Ohio	125	wheat straw	<i>Harmolita hordei</i>	15
1933	Virginia	2	?	?	9
1943	Arizona	numerous	hay	?	12
1950-2	Indiana and nearby	1823 +	wheat straw	<i>Sitotroga cerealella</i>	
				<i>Harmolita tritici</i>	4
1958	California	?	hay	<i>Anthonomus eugeni</i> ? †	15
1960	Nebraska	Several	bromegrass seed	<i>Harmolita tritici</i> ? ††	15
1960	Hawaii	5	termite infested wood	<i>Cryptotermes brevis</i>	2***
1961	Pennsylvania	Several	straw	?	15
1961-62	Georgia	4 + 3	beetle infested wood	<i>Anobium punctatum</i>	This report

* Probably *Pyemotes ventricosus* dermatitis.

** First conclusive demonstration of *Pyemotes ventricosus* as cause of groin itch.

*** Reported as *Pyemotes boylei* Krczol, 1959.

† A simultaneous outbreak of *Anthonomus eugeni* occurred.

†† A simultaneous outbreak of *Harmolita tritici* occurred.

mounted by a pinhead sized vesicle. The clear fluid becomes purulent in a short time if it is not excoriated. There is intense pruritus associated with these bites and frequently secondarily traumatized lesions predominate. The majority of the lesions are found on the trunk but all parts of the body may be affected with the possible exception of the face, hands, feet and mucous membranes. The morphology and distribution of these lesions are unique and make differentiation from other entities such as urticaria, erythema multiforme, drug eruptions, and varicella possible. A central hemorrhagic punctum is seen frequently (Figure 2) and following resolution of the acute phase ecchymoses and brownish pigmentation, probably hemosiderin, remain. The clinical features are fairly characteristic and not easily confused with other clinical entities with the exception of bites from other sources. Arnold and Haramoto² claim to be able to differentiate the bite of *Pyemotes ventricosus* from others but it is doubted that this can be done without considerable experience in the field.

Epidemiologic Aspects

A number of epidemics of dermatitis have been traced to *Pyemotes ventricosus* (Table 1), and it is probable that many other outbreaks have never been reported to physicians, while still others have never been diagnosed.

Infestations have been associated with sleeping on straw mattresses, laboring in grain fields at harvest time, or otherwise coming in contact with or handling grains, straw, hay, grasses, or even beans, peas, cottonseed, or other materials that may be infested with larvae that are attacked by these mites.

The cases involved in the present study were associated with a massive infestation of the common



Figure 7

Anobium punctatum, the common furniture beetle x 8.

furniture beetle, *Anobium punctatum* (DeGeer) (Coleoptera, Anobidae) in the floor joists of a house (Figure 7). Spraying of the infested wood with o-dichlorobenzene solution to control the beetle infestation may have resulted in rapid reduction in numbers of host larvae and the mites dispersed in search of hosts (cf. Reference 2). Another possibility is that as adult beetles emerged and left the wood, the mites migrated in search of new hosts. The importance of this second possibility is dramatized by the second outbreak almost exactly one year later. Two of the cases reported were associated with lying on the floor (the mother to relieve headache, the entomologist to collect the mites), while the milder cases (the husband and the daughter) were probably from limited contact with infested items picked up from the floor. One individual spending time in the infested house (the physician) was not attacked.

The mites were brought under control by treating the floors of the house with two per cent deodorized malathion emulsion.

Anobium punctatum has not been reported previously as a host for *Pyemotes ventricosus*, although Webster¹⁵ reports it parasitizing "wood boring beetles;" and also reports it attacking Cerambycidae and Buprestidae, both wood-damaging beetles.

- 17 hours after exposure
- 28 hours after exposure
- accidental laboratory re-exposure at 96 hours
- ★ 27 hours after second exposure

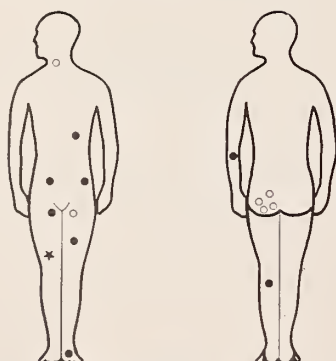


Figure 4

Distribution of *Pyemotes* bites on entomologist.

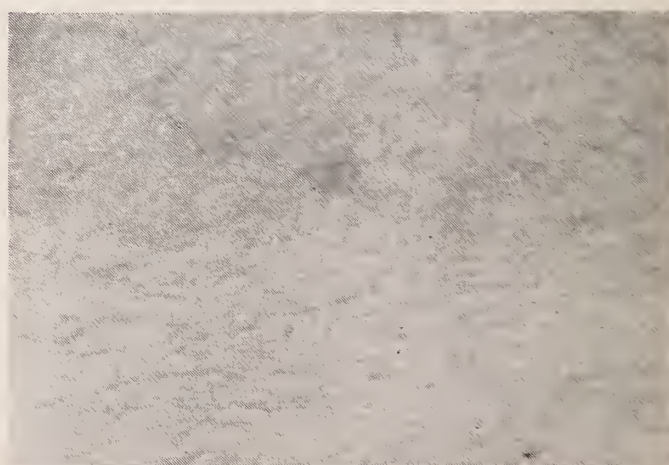


Figure 5

Closeup of *Pyemotes* bite on entomologist (cf. Figure 2). Note minimal degree of reaction as compared to the patient.

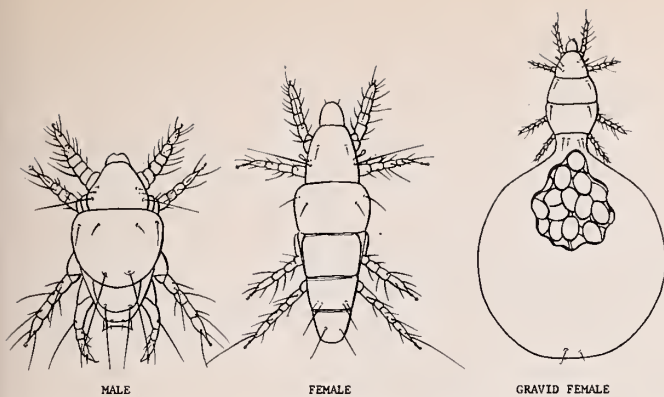


Figure 6

Pyemotes ventricosus, the straw itch mite, male and female x 300, gravid female x 150.

Pyemotes ventricosus (Newport) (Figure 6), world wide in distribution, is a white to yellow, predaceous mite barely visible to the naked eye.³ This mite has been reported attacking, and often killing, the larvae or nymphs of a number of insects, including (all of these hosts probably occur in Georgia):

MOTHS:

Angoumois grain moth, *Sitotroga cerealella* (Olivier)
Pink bollworm, *Pectinophora gossypiella* (Saunders)
Peach twig borer, *Anarsia lineatella* Zeller

WEEVILS:

Boll weevil, *Anthonomus grandis* Boheman
Pepper weevil, *Anthonomus eugeni* Cano
Bean weevil, *Acanthoscelides obtectus* (Say)
Pea weevil, *Bruchus pisorum* (Linnaeus)
Rice weevil, *Sitophilus oryza* (Linnaeus)
Granary weevil, *Sitophilus granarium* (Linnaeus)

BEETLES:

Flatheaded wood borers, Buprestidae
Roundheaded wood borers, Cerambycidae
Bark beetles, Scolytidae
Common furniture beetle, *Anobium punctatum* (DeGeer)
—this report

WASPS AND BEES:

Wheat straw-worm, *Harmolita grandis* (Riley)
Wheat jointworm, *Harmolita tritici* (Fitch)
Barley jointworm, *Harmolita hordei* (Harris)
A solitary bee, *Anthophora vetusta* (nomina obscura)

BUG:

Periodical cicada, *Magicicada septendecim* (Linnaeus)

FLY:

Wheat stem maggot, *Meromyza americana* Fitch

TERMITE:

Tropical powder-post termite, *Cryptotermes brevis* (Walker)

It also attacks man, horses, cattle, and possibly other mammals, producing a dermatitis known commonly as straw, grain, or hay itch. It becomes a problem to man especially when (1) an individual comes in contact with a large quantity of infested material, (2) when the hosts are killed or migrate in large numbers leaving the mites to search for new hosts. It may become a problem among insect cultures in entomological laboratories.

The following combination of characters serves to distinguish *Pyemotes ventricosus* from all other mites parasitic on man³:

- (1) minute (length: male 0.16 mm; female 0.22 mm; gravid female up to 2.0 mm).
- (2) abdomen with traces of segmentation laterally.
- (3) club-like hair between legs I and II (female only).

The male spends its life wandering over the distended abdomen of the pregnant female on which it feeds parasitically. Within the enlarged abdomen of the female the large eggs hatch, and the young mites develop to adulthood within the body of the mother before being extruded (6-10 days from fertilization to hatching). The number of offspring produced by a female is 200 to 300, about three per cent of which are males. Young are extruded at the rate of about 50 per day. The males emerge first and remain clustered around the genital opening of the mother. When a young female is about to emerge, she moves to the mother's genital opening. The male appears to be aware of what is happening and also moves to the opening. With the aid of his powerful hind legs, he seizes the young female and completes her birth by dragging her through the opening. The two then copulate immediately. The females, after mating, scatter in search of hosts. The male does not assist in emergence of young males, and even the young females can emerge without assistance. Development and growth occurs most rapidly at about 75°F.^{6,7,13,16}

The authors raised the mites with no difficulty by placing living females into a screen-top colony of saw-toothed grain beetles, *Oryzaephilus surinamensis* (Linnaeus) feeding on oats. A pan of mineral oil is placed under the colony to prevent escape of the mites (Figure 8).

Summary

Four cases of *Pyemotes ventricosus* (straw itch mite) dermatitis occurred in DeKalb County, Georgia, in June 1961. Three of these cases recurred in

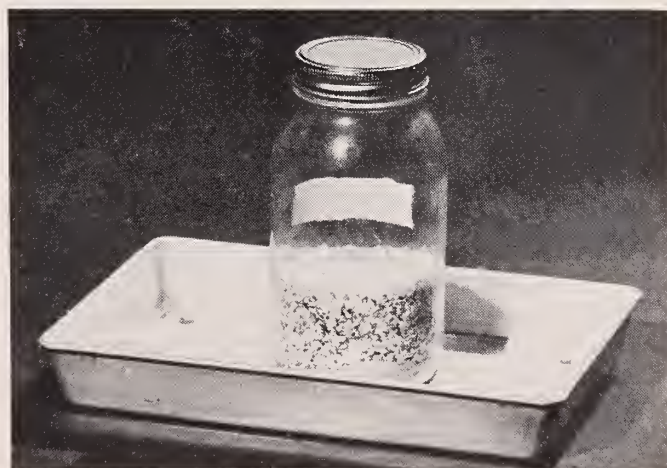


Figure 8

Pyemotes ventricosus colony (using saw-toothed grain beetles as hosts for the mites).

May 1962. The cases were associated with mites parasitizing *Anobium punctatum* (common furniture beetle) in the floor joists of a house. Clinical features, epidemiology, and entomologist aspects are discussed.

Decatur Federal Building

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JOINT PROGRAM TO PROVIDE ACCREDITATION FOR HOSPITALS

The hospitals and medical associations in Georgia have voluntarily set up a joint program to provide consultation and guidance to hospitals in reaching standards for accreditation. The voluntary organization to which many physicians and professional hospital administrators give their time is called the Georgia Hospital-Medical Council. The unique program has already attracted national attention, according to the Georgia Hospital Association.

Sponsors

Prime sponsors of the program, which began three years ago are the Georgia Hospital Association, the Medical Association of Georgia and the Georgia Association of Hospital Governing Boards. To assist in evaluating patient care standards in hospitals a number of medical specialty groups—through their own professional societies—are also represented on the Council and give their time. These include specialists in radiology, pathology, anesthesiology, surgery, obstetrics, internal medicine and others.

"Accreditation as applied to hospitals, is voluntary, and is to be distinguished from licensure. Hospitals are licensed by the State, and a license is required by law. Licensure is primarily concerned with the safety and adequacy of a hospital's physical plant and equipment.

The national accreditation program for hospitals confines itself largely to the medical aspects of hospital services. Though not required of any hospital, the status of accreditation is a mark of assurance to the public that a hospital is adhering to nationally accepted standards in its personnel and services.

The Georgia Council's work in behalf of hospital standards is done entirely by volunteers, and its services are available to hospitals only upon request. Basically,

the service consists of sending a team (one physician and one hospital administrator) from outside the community to inspect and evaluate the services of a given hospital. A standards manual and check lists for all hospital departments are used by the team. Final evaluation is done by the full Council, including a complete report back to the hospital. Any deficiencies are noted along with recommendations for correction.

Since the Council's minimum standards are similar to those required by the national Joint Commission on Accreditation of Hospitals, its evaluations and recommendations provide a valuable guide to hospitals that plan to seek accreditation from the national agency.

The Georgia Hospital-Medical Council gives priority on the time of its volunteers to the smaller hospitals—particularly those of under 25 beds in size. Hospitals of this size are not eligible to apply for national accreditation, and the Georgia Council has moved an accreditation program of its own for this group. There are over fifty hospitals in Georgia that have fewer than 25 beds. In these instances, Council approval of the hospital includes the award of a certificate of accreditation.

Added Recognition

Added recognition and impetus have been given the program of the Georgia Hospital-Medical Council by the Georgia State Department of Welfare. In its medical care program for the indigent aged, the Welfare Department has authority to approve or disapprove a hospital for participation. Nationally accredited hospitals are automatically approved for the welfare aged program. Other hospitals (of any size) must obtain approval. In granting approvals the Welfare Department bases its decision largely on the recommendations of the Hospital-Medical Council.

CARPHENAZINE IN THE WITHDRAWAL PHASE OF ACUTE ALCOHOLISM

Vernelle Fox, M.D., *Atlanta*

■ *This newer phenothiazine derivative proved to be a satisfactory agent in the treatment of the acute alcoholic.*

TO UNDERSTAND THE PHILOSOPHY of the treatment of alcoholism we need to examine our theory of the nature of this illness. We see addiction to alcohol as the patient's means of adjusting to what, to him, seems to be an intolerable combination of his personal dynamics and interpersonal relationships.

Regardless of the markedly diverse underlying psychopathology (and we see the gamut from very little to overt psychosis) and regardless of the environmental circumstances, these patients have many difficulties in common. Some of the more obvious of these are (1) a relatively low ego strength; (2) a tremendous ability to remain unaware of their own feelings; (3) marked feelings of insecurity and isolation, with consequent need to control; and (4) inability to delay gratification and; (5) the relief of discomfort by means of alcohol. In addition, there are usually some metabolic abnormalities and physical derangements, frequently quite severe, secondary to the excessive use of alcohol and malnutrition.

Take-Give Proposition

Recognizing that the prolonged, gradually increasing dependency on alcohol has, for most patients, replaced all other defense patterns, we realize that we are asking a great deal when we ask a patient to stop drinking. To expect this much, a treatment program should be prepared to give a lot in return. We feel that it is not only just, but essential to success, to take a patient pretty much on his own terms. This also means we must work with him

"where he is," not where we wish him to be. "Where he is" often includes severe physical illness and the need of emergency medical attention.

The Facts

When he looks at the facts, no conscientious physician can maintain the old attitude of, "I don't fool with drunks," or "Let him shake it out in jail." In something over 5,000 private patients treated during the withdrawal period, approximately four per cent have developed clinical delirium tremens; and over 15 have died in spite of good medical attention. This series was made up of patients from the average socio-economic background and does not include "skid row" or indigent patients. This means that the "typical" alcoholic has about a 0.4 per cent chance of dying during the withdrawal period. Compare this with the approximately 0.2 per cent chance an individual has of dying from general anesthesia and look at the special precautions we take to trim the latter mortally risk. We believe that all alcoholics, except possibly those with advanced organic brain damage and chronic schizophrenics, could be helped if treatment routines had enough to give them—enough time and interest as well as a sufficiently varied approach.

We know that at our present level of knowledge and availability of special services we are a very long way from this ideal. In the meantime, it behooves us to continue to try to improve our techniques and to continue our search for more adequate

management of the withdrawal symptoms and the underlying chronic anxiety and/or depression.

We have in the past made use of every available medication in the attempt to control these symptoms. Barbiturates, chloral hydrate, paraldehyde, alcohol, intravenous glucose and insulin, ACTH, and other standbys have all been used, but each has serious, well-known drawbacks which preclude its use in many individuals and in some circumstances. Older therapy usually involved several of these measures used together and was never highly successful in reducing the duration of the syndrome or the need for alcohol substitutes. Unless dangerously large amounts of depressant drugs were employed, nursing care remained complex and extremely difficult.

When the newer ataractic agents came along, they were a distinct boon in treating these conditions. Chlorpromazine was the first to be used, and its advantages were immediately realized. We previously reported its use alone and with meprobamate, with which we were able to reduce the average hospital stay by one day and to greatly curtail the amount of alcohol demanded by our private patients.¹ But chlorpromazine also has its disadvantages, which have been widely discussed and publicized.

Promazine Substituted

Promazine was soon substituted for chlorpromazine, and proved an extraordinarily good agent for managing both the acute and chronic phases of alcohol withdrawal.^{2,3} Other investigators have also found it to be of great value in inducing sleep and quiescence⁴⁻⁶; control of nausea, vomiting and gastritis;⁷ and preventing or clearing delirium tremens and reducing the number of convulsions.^{8,9} Hart¹⁰ recently demonstrated that it is superior to paraldehyde in returning all patients without delirium tremens to normal patterns of eating, sleeping and calmness.

The favorable reports which have been appearing on the use of some newer phenothiazine derivatives have prompted this present study. Kofman¹¹ used reserpine in 163 and perphenazine in 114 acutely intoxicated patients, including some with delirium tremens. He compared his results with an earlier series of over 500 who had been treated with intravenous glucose and insulin, and found perphenazine was the most effective treatment. Nearly all patients quickly settled down and resumed physiologic normality within a period of 12 to 24 hours, with evidence of few troublesome side actions. Greenfield¹² reached a similar conclusion after using perphenazine in 70 acutely inebriated patients, all of whom became quiet and cooperative so that specific

therapy could be more easily applied. He regarded perphenazine as a particularly useful drug for the symptomatic management and control of acute alcoholic intoxication.

Carphenazine*, a closely related compound, has presumably not been tried in this application, but is known to have similar pharmacologic actions to perphenazine with lower toxicity and extrapyramidal reactivity.¹³ This compound was substituted for promazine in our private patients and the results were compared with those from former treatments.

Scope and Method

Ninety-six patients were treated in 98 admissions. There were 79 men and 17 women, ranging in age from 26 to 68. The mean age was approximately 45 years. Drinking had been a problem with them for a period from one to twenty years. A majority were spree drinkers. All were suffering the acute after-effects of an extended period of drinking. Although the pattern varied widely, most commonly the patient had been drinking at least one week. Delirium tremens were present in one patient at admission and, on the basis of present symptoms and past history, was impending in at least 25. It subsequently did develop in 13. Besides alcohol, four were also addicted to other agents. In 14, there was an acute brain syndrome associated with alcohol, and in one a chronic brain syndrome.

Frequently occurring complaints and physical findings, one or more of which was present in every patient, included fever, confusion, nausea and vomiting, convulsions, blackouts, liver damage or disease, bruises, dehydration, hallucinations and other symptoms of delirium, malnourishment, teeth in poor repair, chronic cough, asthma, emphysema, anxiety, depression, hernia, hypertension, tachycardia, sore throat, heartburn, anorexia, restlessness, tension, injuries from falls or car accidents, irritability and tremor. Special conditions seen in individual cases included diabetes mellitus, chronic pancreatic insufficiency, whiplash injury of the neck and fibrositis, mental deficiency and anxiety reaction, hypertensive cardiovascular disease, radial palsy, and multiple drug addictions.

Principal Medication

Carphenazine was the principal medication employed. In 59, this was initially given in a dose of 20 or 25 mg. by the intramuscular route, and was repeated only once in two patients. Oral administration was then begun; 25 mg. of carphenazine was given every two to four hours, most often every four hours. In the remaining 39 patients, oral dosage was used both for starting and maintaining treatment.

* Proketazine®, Wyeth Laboratories.

most frequently at a level of 12.5 or 25 mg. four times daily but sometimes as high as 25 mg. every four hours.

Since carphenazine is primarily an antipsychotic agent with little sedative or hypnotic action, other medications were also employed for all except a few patients. Sixty-four received an average of eight doses of 100 mg. hydroxyzine hydrochloride, and 18 received an average of 4.7 doses of 200 mg. meprobamate. Other psychotropic compounds prescribed were azacyclonol, in five patients; hydroxyzine pamoate, in two; promazine hydrochloride in two; and dilantin sodium, cyproheptadine, thioridazine, methocarbamol and chlorpromazine each in one patient. Hyaluronidase, 1/3 cc., was often injected with carphenazine in an attempt to aid dispersion from the muscular site and make the injection less painful.

Evaluative Criteria

For this study, evaluative criteria were established which would allow comparison of the performance of carphenazine with that of other medications formerly used. Improvement would now be rated as *marked* only if: (a) the patients withdrawal symptoms — tremor, nausea, anorexia, insomnia, confusion, agitation, gastritis — were fully cleared within three days; (b) no barbiturates, chloral hydrate, paraldehyde, insulin and glucose, or ACTH were needed in order to accomplish this; (c) no special nurses or restraints were required, which in turn implies that boisterousness, aggressiveness, or violent agitation gave way to calm and sleep during the first hours; (d) withdrawal period was unattended by unfavorable effects, complications or side actions from the treatment; (e) less than three ounces of alcohol was demanded by the patient for "tapering off;" and (f) at discharge, the patient's attitude toward his problem had undergone some change, so that he either had intention of seeking long-range help or was better oriented and had more self control. *Moderate* improvement had occurred when conditions (a), (b), (c) and (d) were fulfilled. *Slight* improvement was not recorded unless at least three of the conditions were met; and of course this implies that even when improvement was rated as *none*, some desirable changes could have been seen.

Results

Withdrawal symptoms cleared within three days in 55 per cent of these patients (in 76 per cent of those who received carphenazine initially by the intramuscular route). The rest (45 per cent) required only a day or so more to revert to physiological normalcy. During this extended period, carphenazine

was continued as a conjunctive measure.

Marked improvement occurred in 18 of the 96 admissions, or for an incidence of 19 per cent, and moderate improvement in an additional 21, or 22 per cent, bringing to a total of 41 per cent the incidence of marked or moderate improvement for this series. On the basis of the presently established criteria, only about eight per cent of those in a previous study employing chlorpromazine and meprobamate would have met all six of the conditions and would have qualified as markedly improved; an additional 15 per cent would probably have been judged to have been moderately improved.¹ Other therapies formerly used would have had far fewer patients placed in these categories. Only eight per cent of the patients in the present series were estimated to have made "no" improvement.

Side reactions were nearly nonexistent. One patient claimed that his jumpiness, dizziness and nausea were due to the medications. In another, there was a questionable drop in blood pressure and some orthostatic hypotension.

Special mention should be made of the painful nature of the intramuscular injection. Even with the use of hyaluronidase, and in a few instances in which procaine was used, 12 patients complained of the stinging and burning. In view of the otherwise excellent results obtained through this route of administration, this difficulty is unfortunate. Patients receiving a first intramuscular injection were reluctant to undergo a second one.

Favorable Comparison

My general impression was that this compound compared quite favorably with any that had been used before, including promazine, chlorpromazine, triflupromazine and other phenothiazine derivatives. There was less dryness of the mouth. Tremor and anxiety responded quickly and completely to 25 mg. four times a day for most patients. Patients ate and slept very well, even during the acute withdrawal period. There was as good control of nausea and vomiting as with any other medication. We encountered no extrapyramidal tract symptoms, even with high dosages.

It is most difficult to persuade alcoholics to remain in the hospital even long enough to completely "dry out" and to work through their current crises of anxiety, guilt and depression, much less to begin to accept the seriousness of their problem and the need for long range help. For those who would remain in treatment for longer periods, carphenazine was continued as a conjunctive measure.

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THE MAP FOR THE MONTH OF April shows an improvement over the preceding months. Although 13 stars are by no means enough to "pepper" the state, it is evidence that the doctors are reaching the lay public through a concerted effort. The response from the medical profession to the plea for more communication is beginning to gain impetus, and it shows. After six months of the Journal's "new" feature, the profession is finally responding. Doctors who are passing through Atlanta and manage to stop by the Headquarters Office have made a special effort to report the speeches they and their colleagues have made in the last month. The postcards sent to each County Society Secretary are becoming a more familiar sight in the Journal office, and one doctor has even asked for more. But one man asking for more is still not enough. By October 1963, when this feature is one year old, the map should have 50-100 stars. And this should be just a beginning. County Society Secretaries may obtain more postcards by writing to the Journal office, and any doctor who stops by the Headquarters Office at any time, will be doubly welcome when he reports that he or his friends have made a speech to the lay public anywhere in the state of Georgia.

How well are we telling our story?



RECOGNITION OF THORACIC SURGICAL EMERGENCIES IN INFANTS

William E. Laupus, M.D., and Robert G. Ellison, M.D., *Augusta*

- *Many of these thoracic surgical problems can be recognized early enough to permit surgical intervention before a genuine emergency situation develops.*

IN A COMPANION PAPER,¹ the authors have discussed the management of thoracic surgical emergencies in infants. The surgical philosophy, currently in practice in the Eugene Talmadge Memorial Hospital, calls for aggressive application of surgical technical skills in infants with serious and lethal intra-thoracic disease. Although aggressive in concept, the approach of the surgeon is at the same time conservative in that palliative or staged procedures are performed whenever total surgical repair is associated with higher operative mortality; complete correction of the defects are then postponed until the infant has reached an age and size which permits more extensive and anatomically corrective surgery with lessened morbidity and mortality. The earlier recognition of these thoracic surgical problems which frequently present as emergency situations is mandatory if optimal surgical benefits are to be offered these infants.

Little Change in Mortality

Neonatal and infant mortality rates have shown little change despite the great advances in diagnostic and surgical techniques which have become available during the past 15 years. Clearly, further

decline in infant deaths must come from earlier recognition of potentially serious disease in a number of small areas of major medical concern. One such group of patients presents problems involving either the lungs alone or both the cardiovascular and pulmonary systems. Although exceptions may be found to the general discussion which follows, many of these thoracic surgical problems actually can be recognized early enough to permit surgical intervention before a genuine emergency situation, calling for immediate action and associated with excessive risks, has developed.

Proper Assessment

Proper assessment of the problems of these infants requires diligent attention to well-known and simple rules of good medical practice—the taking of a complete medical history, the doing of a careful physical examination, the selection of fruitful laboratory procedures and the interpretation of these data and observations in terms of a keen knowledge of the diagnostic probabilities. In taking the medical history, the physician will wish to extend his inquiry beyond the usual symptomatology of respiratory and cardiac origin to the areas of feeding and physical development, both of which are commonly impaired

¹Presented at the 108th Annual Session of the Medical Association of Georgia, May 8, 1962, Savannah, Georgia.

in these infants. He will want to know the frequency and seriousness of antecedent illnesses which may suggest the possibility of complications of infection. Once the history has been established, observation of the patient prior to actual physical examination will often be very revealing. The physician will want to make note of the presence of cyanosis or pallor; he will observe the respiratory rate and respiratory effort, looking carefully for evidences of retraction, asymmetry of the chest and of respiratory excursion, dilatation of the alae nasi, the utilization of accessory respiratory musculature and other evidences of respiratory abnormality. A detailed physical examination emphasizing auscultation, palpation, and percussion will seek signs of hyperresonance or dullness, changes in breath sounds, cardiac enlargement, thrills and murmurs. The presence or absence of the normal heart sounds will be carefully noted. Murmurs, when present, will be identified by location, transmission, character, time of appearance and grade of maximal intensity. Special attention will be given to palpation of the radial, femoral and dorsalis pedis pulses and to determination of the blood pressure in both the upper and lower extremities. Interpretation of abnormal physical findings will be frequently enhanced by X-ray and electrocardiographic studies.

Categories of Problems

The problems which have been selected for presentation are readily divisible into non-cardiac and cardiac groupings. Five non-cardiac diseases with unilateral localization—pneumothorax, diaphragmatic hernia, lobar emphysema, “congenital” cysts and pyopneumothorax—share many characteristics in common. Increased respiratory rate, atelectasis, mediastinal shift, lagging and asymmetrical inspiratory excursions, changes in the percussion note and auscultatory aberrations result from mechanical interference with lung expansion by these space-occupying lesions. Symptoms may appear abruptly or may be of more gradual onset with the earliest symptom being unexplained tachypnea. A newborn with the history of positive pressure resuscitation coupled with the findings of a hyperresonant percussion note and the other localizing signs of interference with lung expansion will most likely have pneumothorax as the cause for his respiratory distress. Similarly, these findings in a somewhat older infant will be more commonly the result of lobar emphysema or “congenital” cyst of the lung. The diagnosis of either of these entities is more secure if expiratory wheezing, due to bronchial compression, is present. An infant who historically has had a recent upper respiratory infection accompanied by

low-grade fever and cough may well have a staphylococcal pneumonia with a complicating pyopneumothorax when presenting these physical findings. In most instances, a standard postero-anterior X-ray of the chest will confirm the impression of the physician. Proper surgical therapy should follow promptly.

Diagnostic Clues

Clues to the diagnosis of congenital esophageal atresias with tracheoesophageal fistula will include an abundance of secretions in the mouth due to the esophageal obstruction; the presence of dyspnea resulting from the aspiration of and/or regurgitation of gastric secretions through the fistula into the trachea and thence into the pulmonary parenchyma; and distention of the stomach resulting from the passage of air through the fistula between the trachea and lower esophageal segment into the stomach. Certainly in the newborn infant the combination of excessive mucus and dyspnea will call for the passage of a firm but not stiff number eight French rubber catheter through the mouth into the esophagus to determine its patency. Occasionally, an overly soft catheter will double back upon itself giving the false impression of esophageal patency. A small amount of air injected rapidly through the tube will usually be easily heard with a stethoscope if the air enters the stomach. When doubt still exists after this maneuver, a chest X-ray to reveal position of the catheter or the passage of the catheter under fluoroscopic visualization will aid in resolving the dilemma.

Importance of Cyanosis

Cardiac surgical emergencies are generally separable on the basis of cyanosis. In the infants with cyanosis tetralogy of Fallot, tricuspid atresia and pseudotruncus arteriosus may give similar symptoms consisting, in the main, of attacks of paroxysmal dyspnea with hypoxia of varying degrees. Frequently this paroxysmal dyspnea may lead to loss of consciousness. In the infant, these attacks are most often associated with bowel movements, crying and feedings. They may present as a momentary loss of consciousness with rolling of the eyes and loss of head control or they may last for several minutes culminating in a convulsion. Many infants with either tricuspid atresia or transposition will require urgent attention for congestive right heart failure, whereas, those with tetralogy rarely will develop cardiac decompensation. The time of appearance of cyanosis may prove useful in helping to differentiate these lesions. In transposition, intense cyanosis will usually be present from the time of birth; cyanosis will ordinarily be much more gradual in onset in other conditions. Although the systolic murmur heard in these

anomalies may be similar, careful auscultation at the base of the heart will often be helpful. The presence of a "split" second sound will signify normal aortic and pulmonic valve closures, a finding more likely in transposition than in the tetralogy or the tricuspid atresia where the pulmonic valve closure will be either very soft or absent. Similarly, the second sound in the pulmonic and aortic areas will be single in the truncus and pseudo-truncus arteriosus anomalies. Chest X-rays will usually show ischemic lung fields due to reduced pulmonary blood flow in infants with tetralogy of Fallot, pseudo-truncus and tricuspid atresia, whereas increased pulmonary vascularity is most commonly present with the transpositions and true truncus arteriosus. The diagnosis of tricuspid atresia will be strengthened greatly if the electrocardiogram reveals left ventricular hypertrophy and little right ventricular activity. In most instances, the electrocardiogram will show marked right ventricular hypertrophy in infants with either tetralogy or transposition. Total anomalous pulmonary drainage in which all of the venous return from both the systemic and pulmonary circulations comes to the right auricle may mimic these other and more common disorders clinically, especially if congestive heart failure is present.

Presenting Emergency Problem

The presenting emergency problem in non-cyanotic heart disease is very likely to be congestive heart failure. Both patent ductus arteriosus and the ventricular septal defect are associated with increased pulmonary blood flow, hypervascularity of the lungs and marked respiratory difficulty. Repeated bouts of pneumonia will be seen often in infants with these conditions. In infancy, the characteristic continuous murmur of the patent ductus arteriosus may be absent, making diagnosis more difficult. The infant with a loud, long systolic precordial murmur, tachypnea and frequent pulmonary infections should be suspected of having one of these two lesions. Quick, hyperkinetic pulses with a wide pulse pressure com-

monly will be noted in patients with patent ductus arteriosus. Since these hyperkinetic pulses may also be associated with large ventricular septal defects, it may be necessary to carry out a cardiac catheterization or retrograde brachial arteriogram to differentiate between the lesions.

Absent or weak femoral arterial pulsations in association with full pulses in the radial vessels and hypertension in the upper extremities should always suggest coarctation of the aorta. Surgical correction of this lesion may be necessary in early infancy if congestive heart failure is present. Isolated aortic stenosis and pulmonic stenosis are common congenital lesions which occasionally require early surgical intervention because of the development of congestive heart failure.

Generalizations

Some generalizations in respect to the anticipation of the serious problems associated with congenital heart disease follow. Because of the greater frequency of symptoms and serious complications in infants with cyanotic heart disease, specific diagnostic studies should be carried out as soon as the cyanosis is recognized. The asymptomatic infant with a heart murmur will need, as a bare minimum, base-line chest X-rays and electrocardiography and early evaluation by a physician experienced in the diagnosis and care of heart disease in infants and children. Definitive diagnostic procedures, such as cardiac catheterization and angiography, will be carried out in infancy if the symptomatology warrants it or when evidence of progressive cardiac enlargement and/or ventricular "strain" is apparent on serial physical and laboratory examinations. The mortality of infants with serious heart lesions will be reduced only when the finding of minor or major signs pointing to cardiac disease is regarded as a "danger signal" of sufficient importance to make imperative the careful evaluation of the cardiovascular system at the earliest opportunity.

Talmadge Memorial Hospital

NEW MEDICAL PRACTICE UNITS 'PLANNING GUIDE' OFFERED BY AMA, SEARS-ROEBUCK

The American Medical Association, in conjunction with the Sears-Roebuck Foundation, has recently published a new planning guide for establishing medical practice units. Done on heavy vellum paper and consisting of 82 pages, the guide, of which there is only a limited supply, is available to any doctor. The guide contains suggestions on location, hospital and patient accessibility, size, property costs, shape and placement of building, climate, parking, landscaping, remodeling,

and a number of other important ideas regarding a medical office. Floor plans for each room needed in an office are given in black and white scale drawings and several suggested plans for two and three man offices are shown. Examples of "do-it-yourself" possibilities for medical practice facilities are illustrated along with lists of equipment and their prices. Doctors interested in obtaining the new planning guide should write to the Medical Association of Georgia Headquarters Office, 938 Peachtree St., N.E., Atlanta 9, Georgia.

BONE DISEASE OF RENAL ORIGIN

Gordon C. Miller*, *Augusta*

■ A timely review of five different types of nephrogenic bone disease is presented.

THE PHYSICIAN who first sees a patient with such non-specific symptoms as backache, leg pain, bow-legs, or generalized radiolucency of bone indeed has a diagnostic problem, for a great many diseases may look superficially alike. He cannot naively consider that every case of bowed legs is due to a dietary deficiency of vitamin D. Today classical vitamin D-deficient rickets is very rare in the United States, so any child with rickets or adult with osteomalacia should be examined for a renal malfunction.¹ To establish an etiological diagnosis he will need to begin with a thorough history and physical examination, roentgenograms of the skeleton, analysis of serum calcium, phosphorus, chloride, and alkaline phosphatase, and of urinary calcium and phosphorus. Generalized decrease in bone density cannot differentiate between such diseases as osteoporosis, osteomalacia or osteitis fibrosa cystica.² One, of course, recalls that osteoporosis is a decreased formation of matrix, and osteomalacia is decreased calcification of bone; rickets is the later process in children. Osteitis fibrosa is due to increased resorption of bone due to parathormone action. Renal diseases may produce osteomalacia, rickets, osteitis fibrosa cystica, osteosclerosis, or a combination of them.³

At present, there seem to be five different nephrogenic bone diseases:

- (1) Vitamin D-resistant rickets.
- (2) Idiopathic hypercalciuria.
- (3) Renal tubular acidosis.
- (4) De Toni-Fanconi Syndrome.
- (5) Azotemic osteodystrophy.

The first four produce rickets or osteomalacia as the

predominant lesion; the fifth causes not only osteomalacia or rickets but at times also osteitis fibrosa, osteosclerosis, metastatic soft tissue calcification, or a combination of them.

(1) *Vitamin D-resistant rickets*. The old theory of the pathogenesis of this disease was that the tubules fail to resorb phosphorous properly—the so-called “phosphate diabetes.” Hyperphosphaturia was thought to be followed by hypophosphatemia and a low calcium x phosphorus product, and then rickets.

But currently the primary defect is believed to be increased vitamin D-resistance. This causes hypocalcemia which is followed by secondary hyperparathyroidism and osteomalacia. The negative phosphorus balance is therefore attributed to the hyperparathyroidism. As an equation:

increased vitamin D-resistance	→	hypocalcemia	} secondary hyperparathyroidism osteomalacia

Clinically there is delayed dentition, knock knees, bowlegs, waddle, kyphosis and dwarfism. The histological changes are those of classical rickets.⁴ Laboratory values show: BUN normal, serum calcium normal or increased, phosphorus decreased,⁵ and alkaline phosphatase increased or normal. Urine Calcium is decreased and urine phosphorus is increased. Treatment consists of vitamin D in doses as high as 400,000 units per day.⁶ If begun early enough, it corrects the bone disease by normalizing the calcium content of serum.

(2) *Idiopathic hypercalciuria* is a renal defect in which calcium is lost to excess in the urine with consequent hypocalcemia. The hypocalcemia is fol-

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lowed by osteomalacia and to a lesser extent by secondary hyperparathyroidism. In fact, osteomalacia of any kind is accompanied by a certain amount of osteitis fibrosa.^{7,8} Other renal functions are usually normal, but the hypercalciuria commonly leads to renal stones.

(3) *Renal tubular acidosis* should also be suspected in any person with renal stones, osteomalacia or both. It is characterized by a metabolic acidosis with high serum chloride, low serum bicarbonate and, paradoxically, an alkaline urine. Of the many theories of its pathogenesis that have been proposed, the most prominent are: (a) failure of the distal tubular secretion of hydrogen ion, (b) failure of bicarbonate reabsorption in the proximal tubule, (c) excessive chloride reabsorption from glomerular filtrate, and (d) a defect in carbonic anhydrase function.¹⁹

Child and Adult Lesions

In the child, the lesion is rickets, delayed closure of the fontanel, short stature, limb deformities, generalized bone radiolucency, large goblet-shaped ends of metaphyses, or absent zones of calcification next to the metaphysis. In the adult the lesion is osteomalacia with general radiolucency, bending of bones, pseudofractures (zones of no calcification), and pain in the hips and legs.⁹ Since patients may have bone pain and histological osteomalacia with a negative X-ray, a biopsy of the iliac crest is often advised.⁷ Bone must be over 30 per cent deficient in calcium before the change is evident radiologically.² Sometimes the bone lesions are present for years without producing symptoms.⁷ When given ammonium chloride, the serum bicarbonate drops lower, and the chloride rises higher than the normal person's would. Early the BUN is normal. Later, calciuria and alkaline urine are complicated by renal stones and infection. Treatment is the administration of base and large doses of vitamin D.^{9,5,17} The failure of calcification of bone in rickets probably depends not only on the lack of calcium or phosphorus but also on a deficiency of vitamin D.⁵

(4) In the *Fanconi Syndrome* one also sees rickets and osteomalacia as the predominant bone lesion but in this entity, almost all renal tubular functions are disturbed. They fail to adequately resorb calcium, phosphorus, glucose, potassium, water, protein and amino acids. There is often metabolic acidosis. The exact mechanism has not definitely been determined, but calcium and phosphorus are not adequately absorbed from the gut. Morphologically, the proximal tubules are shriveled and have a swan's neck appearance. There is a deleterious deposition of cystine in the tissues but it is usually not one of the amino acids found to excess in the urine.²⁰ Treatment of the bone disease again is very high doses of vitamin D.

(5) In *azotemic osteodystrophy* the renal lesion involves both tubule and glomerulus. Many processes cause chronic azotemic renal failure; congenital hypoplasia, polycystic disease, hydronephrosis, or pyelonephritis are common.¹⁰ The predominant skeletal lesion is osteitis fibrosa.¹¹ The renal disease may or may not produce overt symptoms such as thirst, nocturia, anemia, hypertension, isosthenuria, and proteinuria, but azotemia is by definition constant. Both children and adults are affected, but it is more frequent in children. The child may be dwarfed due to arrest of endochondral growth at the epiphysis, with bowlegs or knock knees due to enlarged costo chondral junctions. The adult may present with painful osteomalacia of the legs, hips or back, difficulty in walking and sometimes with fractures of ribs.⁷ Just as there are latent renal symptoms, the bone disease also may exist for years without producing symptoms and may be noted as a generalized radiolucency on a roentgenogram made for some other purpose. Histological lesions can be demonstrated by biopsy, even in adults, after only one year of renal disease.¹²

There is usually metabolic acidosis but not always. Serum phosphorus is usually increased but may be normal or decreased. Serum calcium is usually normal but occasionally is low or high. Alkaline phosphatase is usually increased.⁷ When vitamin D is given for osteitis fibrosa, the radiological impression of healing may be illusory for even in densely sclerotic and heavily mineralized bone evidence of extremely active osteitis fibrosa has been found. This is one reason why high dosage vitamin D-recalcification therapy may be dangerous in patients with overt osteitis fibrosa. Even though the greater part of retained minerals is deposited in the skeleton, it is likely to be released therefrom by the continued hyperparathyroid activity.⁷ This suggests autonomy of the parathyroid glands.

Theory Fragmented

In an effort to explain this disease it was formerly proposed that chronic renal failure with its phosphorus retention in turn depressed serum calcium; hypocalcemia then caused osteomalacia and secondary hyperparathyroidism with osteitis fibrosa.¹³ More recent findings fragment this theory. The serum phosphorus is not always increased, and hyperphosphatemia does not always cause serum calcium to fall. Hypocalcemia by itself without a simultaneous deficit of vitamin D does not produce osteomalacia.⁷ Neither does the old theory explain why some of the bone lesions of renal disease are identical to those caused by vitamin D deficiency; nor does it explain why the administration of vitamin D does not cure osteitis fibrosa.^{7,14} Currently, it appears that diseased kidneys increase the bone's resistance to vitamin D.¹⁵

Azotemic serum seems to neutralize the action of vitamin D in part,¹⁴ and the resulting hypocalcemia and the vitamin D-deficiency together produce osteomalacia. The vitamin D requirements can, however, be overcome by large doses of the sterol, and the bone lesions made to heal.

Severe persistent hypocalcemia may, however, lead to hyperparathyroidism which may become autonomous and not subside even though the serum calcium concentration is brought to normal; vitamin D may heal osteomalacia but not osteitis fibrosa. If, therefore, a large dose of the vitamin is given, a dangerously high rise of serum calcium and metastatic calcification may follow. The only logical alternative then, is near-total parathyroidectomy which allows the osteitis fibrosa to heal and leaves the osteomalacia amenable to vitamin D therapy.⁸ This has been done with gratifying results.^{8,16} Preoperatively there was full blown azotemic renal osteodystrophy—azotemia, painful osteomalacia, osteitis fibrosa and metastatic calcification. After removal of the parathyroid glands, metastatic calcification disappeared and the osteitis fibrosa healed; vitamin D in large doses then normalized the serum calcium content and the osteomalacia subsided with relief of pain.

Summary

Five different types of nephrogenic bone diseases have been briefly discussed. Each may present itself to the physician as any of many symptoms and signs referable to the renal or skeletal system. But after observing their variable and wily nature, it is interesting to note that vitamin D in large doses is used in the treatment of the bone lesions of all the types. And recognizing them is important in that their dis-

abling features are amenable to therapy.

Medical College of Georgia

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GEORGIA HEART ASSOCIATION ANNUAL MEETING PROGRAM ANNOUNCED

Guest faculty for the Georgia Heart Association's 15th Annual Meeting and Scientific Sessions at the Atlanta Biltmore Hotel on Friday and Saturday, September 20 and 21, 1963, will include:

Dr. Carleton B. Chapman, Professor of Medicine, The University of Texas, Southwestern Medical School, Dallas, Texas:

1. "Changing Concepts of Cardiac Failure"
2. "Mitral Insufficiency"

Dr. William K. Hamilton, Professor and Chairman, Department of Anesthesiology, State University of Iowa, Iowa City, Iowa:

1. "The Subjects of Preanesthetic Evaluation of Patients with Cardiovascular Problems"

2. "The Role of Venous Tone in Circulatory Adjustments in the Operating Room"

Dr. W. J. Kolff, Head, Department of Artificial Organs and Staff Member, Research Division, Cleveland Clinic Foundation, Cleveland, Ohio:

1. "To Live Without Kidneys"
2. "The Present Status of the Artificial Heart Inside the Chest"

Dr. Lawrence E. Lamb, Professor, Internal Medicine, Chief, Clinical Sciences, Division Medicine, Brooks Air Force Base, Texas:

(Will present two papers in the field of electrocardiography; titles of which will be announced at a later date.)

USE OF MAGNETIC FORCE IN REMOVING A METALLIC FOREIGN BODY

W. C. Tippins, Jr., M.D., *Hogansville*

HAVING FOUND THE CHORE OF REMOVING a small metallic foreign body from a patient a most trying and sometimes near impossible ordeal, I would like to submit the following experience in the external use of a magnet in bringing a metallic foreign body into easy reach.

Case Report One

A ten-year-old white female was seen by me with a chief complaint of a sewing needle having been stuck in her right thigh two weeks prior to this visit. The needle was said to have been broken off in the leg and a portion of the "eye end" removed.

Examination of the leg revealed a small, red, elevated area at the site of entrance of the needle; however, nothing was felt on palpation of the area. An X-ray revealed a metallic object resembling a needle deep in the muscle of the right thigh.

A small magnet (obtained from a cabinet door) was taped over the area of the foreign body. The magnet was maintained in position with tape for five days. During this period the patient felt fleeting sharp pains in the region of the foreign body. On the fifth day the magnet was removed and the needle could be palpated its entire length just below the skin. A small incision was made over the foreign body, using local anesthesia, and a needle three cm. in length was easily removed.

A similar case of removal of a curved needle from deep in the buttock using a large permanent magnet taped to the buttock was reported in *J. A. M. A.* by Brod and Schlang.¹

Case Report Two

A thirty-two-year-old white male was seen with a history of having been hit in the right leg by a foreign body thrown by a power mower. The physician

he consulted at that time gave him an anti-tetanus injection and dressed the wound. I saw the patient three weeks later. He was employed as a driver of a large trailer truck and complained of pain in the leg when he applied the brakes on his rig.

An X-ray revealed what appeared to be a curved piece of wire deep in the muscle of the right leg. A small magnet was taped over the area of the foreign body and the patient returned in one week from a trip, reporting the pain had disappeared a few days after the application of the magnet. On examination of the leg, the foreign body could be felt.

The patient's leg was to have been prepared for removal of the foreign body; however, while the nurse was setting up the tray, the patient decided to walk out to his car about a block away. On his returning to the office, the foreign body could no longer be felt and could not be found on opening the leg (demonstrating again the difficulty of removing foreign bodies).

The magnet was reapplied and the patient returned three weeks later (the length of time here was due to a long trip made by the patient in his line of work). The foreign body was again easily felt below the site of the magnet. The patient was instructed not to move, the area was prepared and an incision was made, using local anesthesia, and a curved piece of rusty wire 3.2 cm. in length was removed.

We would suggest that when dealing with a small metallic foreign body in the subcutaneous or intramuscular tissue, the application of a magnet should be considered prior to surgery.

30 Commerce Street

Reference

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1963 CALENDAR OF MEETINGS

State

April 14-June 9—Seminars on the fundamental mechanisms of disease sponsored by the Independent Non-Profit Hospitals of Atlanta: May 12—"Basic Hormone Effects on the Female;" June 9—"Virology; It's Background in Current Clinical Concepts."

April 25—Eighth Annual Albany-Southwest Georgia Medical Seminar, Grand Ballroom, Albany Hotel, Albany.

May 5-8—109th Annual Session of the Medical Association of Georgia, Aquarama, Jekyll Island, Georgia.

May 9—Department of Ophthalmology of the Ponce de Leon Eye and Ear Infirmary, Four Day Contact Lens Seminar for Ophthalmologists and Technicians, Atlanta.

Regional

October 1962-November 1963—Fourteen Postgraduate Courses offered by the University of Tennessee College of Medicine; May 15-17—"Emotional Disturbances of the Adolescent;" May 22-24—"Fractures and Dislocations."

April 16-19—American Dermatological Association, The Homestead, Hot Springs, Va.

April 17-20—Sixteenth Annual Meeting of the West Virginia Academy of Ophthalmology and Otolaryngology, Greenbrier Hotel, White Sulphur Springs, West Va.

April 21-22—American Laryngological Association, Hollywood Beach Hotel, Hollywood, Fla.

April 23-25—American Laryngological, Rhinological, and Otological Society, Hollywood Beach Hotel, Hollywood, Fla.

April 25—American Society for Head and Neck Surgery, Hollywood Beach Hotel, Hollywood, Fla.

May 4-8—Medical Society of the State of North Carolina, Asheville, N. C.

May 6-9—National Geriatrics Society, Royal Orleans Hotel, New Orleans, La.

May 7-9—South Carolina Medical Association, Myrtle Beach, S. C.

May 13-15—American Gynecological Society, Roosevelt Hotel, New Orleans, La.

May 16-19—Florida Medical Association, Diplomat Hotel, Hollywood-by-the-Sea, Fla.

May 27-29—American Ophthalmological Society, The Homestead, Hot Springs, Va.

June 24-27—American Orthopaedic Association, The Homestead, Hot Springs, Va.

National

April 21-24—American College of Obstetricians and Gynecologists, Statler Hilton Hotel, New York City.

May 2-5—Student American Medical Association, Sherman House, Chicago, Ill.

May 27-31—Five Day Refresher Course in Pediatrics for Pediatricians and General Practitioners, The Children's Hospital of Philadelphia, Philadelphia, Pa.

June 3-21—Forty-eighth Session of the Trudeau School of Tuberculosis and Other Pulmonary Diseases, Saranac Lake, N. Y.

June 13-17—Twenty-ninth Annual Meeting of the American College of Chest Physicians, Atlantic City, N. J.

June 16-20—American Medical Association Annual Meeting, Atlantic City, N. J.

MEDICAL STUDENTS SCHEDULE MAY MEETING

More than 2,000 medical students, interns and residents will gather at the Sherman House, Chicago, Illinois, May 2-5, for the 12th annual meeting of the Student American Medical Association.

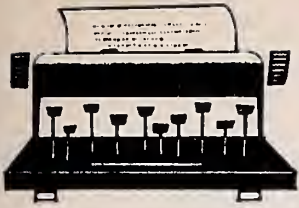
One of the features of the four-day meeting will be a speech by Michael DeBakey, M.D., noted Houston surgeon, on "The Role of the Physician in Our Changing Society." Another highlight will be the speech, "Faith as a Factor in Psychotherapy," by Corbett Thigpen, M.D., co-author of the novel, "The Three Faces of Eve."

The scientific program of the meeting will also include a symposium on "The Newer Uses of Corticosteroid Therapy," chaired by Harley E. Cluxton, M.D., of Northwestern University School of Medicine; the presentation of award-winning scientific papers by SAMA members; and an exhibit of outstanding medical photographs and illustrations.

For legal buffs, SAMA will stage a moot trial, "The Malpractice Trial of Dr. Keasey Kildare," featuring medical and law students assisted by the legal department of the American Medical Association.

Sessions of the SAMA House of Delegates, policy-making body of the Association, will open on May 2 and conclude May 5, with the election of officers for the 1963-64 year.

Other speakers on the program include: Walter Alvarez, M.D., Chicago, "The Vanishing Art of Diagnosing with the Eyes and Ears"; Albert Ritt, M.D., President of the American Academy of General Practice; George Stilwell, M.D., President of the American Medical Writers' Association, "Medical Writing: Its Perils and Pitfalls"; and George M. Fister, M.D., President of the American Medical Association.



Gastric Freezing New Treatment for Peptic Ulcer Diathesis

SINCE THE APPEARANCE of articles in the lay press concerning gastric freezing, there has been an amazing amount of enthusiasm and interest on the part of the public concerning this new method of treatment. This interest has been demonstrated by the number of telephone calls that most physicians have received from their ulcer patients concerning gastric freezing. This was rather surprising to me in the beginning, but it brings to mind once again that peptic ulcer remains a troublesome problem to the patient and at times, to his doctor. We are all familiar with the difficulties encountered by a patient attempting to continue a normal life while on an ulcer diet and multiple medications. When one of the complications of peptic ulcer develops, these difficulties are multiplied many times. With these considerations in mind, it is small wonder that our patients have shown such enthusiasm for this new form of therapy.

Unanswered Questions

There are many unanswered questions concerning gastric freezing. It will take more time and further evaluation of a much larger number of patients treated by this method before the answers we want are available. For instance, the indications for gastric freezing are still not completely defined. In addition, we do not know how long the beneficial results obtained by freezing will persist in a majority of patients treated, and at this time it is impossible to say with certainty that late complications could not develop.

There are many things, however, that we do know. The method utilized in gastric freezing is fairly simple. It involves circulating pre-cooled alcohol through a double lumen tube into a balloon which has been placed in the stomach and distal esophagus. This produces actual freezing of the wall of the stomach. At the controlled temperatures now used, the stom-

ach tolerates freezing for a one hour period quite well, and patients may undergo freezing on more than one occasion without apparent ill effects. There is no gross injury to the stomach other than hyperemia and edema, which are only temporary changes.

Therapeutic Effect

The therapeutic effect of freezing is due to injury to the parietal and chief cells producing impairment in their secretory function. In addition, there is injury to the small sub-serosal vagal nerve fibers and to the ganglion cells in Auerbach's plexuses. This "physiological gastrectomy" is demonstrated in the post-freeze patient by achlorhydria or marked reduction in acid, and a decreased response to the Hollander (insulin) test.

At present gastric freezing is indicated in patients with chronic intractable duodenal ulcer, and in patients who are candidates for surgery because of previous episodes of bleeding or prior perforation with recurrent ulcer symptoms. Selected cases of healed gastric ulcer, stenosing esophagitis, and stomal ulcer are also candidates.

Patients with any significant degree of obstruction and gastric retention, and patients with an active gastric ulcer are not candidates for freezing. Active bleeding is also a contraindication for immediate freezing at this time.

Results Encouraging

Results reported to date are most encouraging with the uniform occurrence of prompt and grateful relief of ulcer pain. Roentgenological evidence of healing of duodenal ulcer occurs within two to six weeks. Symptomatic relief and laboratory evidence of suppression of secretory function is expected in 75 per cent to 85 per cent of the patients. In those

patients with recurrence of symptoms, gastric freezing may be repeated safely after a period of several weeks or months.

Complications using the present technique have been limited to melena in about five per cent of the patients, and a feeling of fullness in the epigastrium in some patients which may persist for a week to ten days. At the University of Minnesota the patients with melena have been treated conservatively, and melena following gastric freezing has not been considered an indication for surgery. Other complications such as the production of a gastric ulcer occurred in some of the earlier patients treated due to technical errors which have now been corrected.

There have been no deaths reported as a direct result of gastric freezing.

Using the same apparatus, gastric cooling (not freezing) has been very helpful in controlling massive bleeding in duodenal ulcer. It is only indicated in those patients who have had sufficient bleeding to

be candidates for surgery. In other words, its use allows one to convert an emergency operation with its increased mortality into an elective operation. Bleeding from esophageal varices is readily controlled by this method and should prove most helpful in the management of these patients.

Summary

In summary, it appears at present that gastric freezing will be a very useful tool in the treatment of a fairly large number of patients with peptic ulcer diathesis. It has proven itself to be much less dangerous than surgery, and it is probable that its use will obviate the necessity for surgery in many patients. In addition, the utilization of gastric cooling will be very helpful in the management of massive bleeding due to peptic ulcer and esophageal varices. I believe that after further evaluation this new method of therapy will prove a helpful and permanent tool in our armamentarium in the management of some of the problems of peptic ulcer and allied conditions.

Charles E. Todd, M.D.

MAA Expansion of Georgia Kerr-Mills

AS SUPPORTED AND ENDORSED by the Medical Association of Georgia, the enabling legislation to permit Georgia to participate in the Kerr-Mills program of health care of the aged was passed in 1961. This law would provide financial assistance for two segments of Georgia's aged population, namely:

(1) Old Age Assistance (OAA) health care benefits for the "needy" who are over age 65 and who are on the Welfare Department rolls, and (2) Medical Assistance to the Aged (MAA) health care benefits for the "near-needy" who are over age 65 and who would be determined medically indigent such as those persons who can live independently yet cannot pay unusual hospital bills.

In January of 1962, Georgia started the OAA part of the Kerr-Mills program which now provides hospital care for any illness or injury requiring hospitalization up to 60 days per year and nursing home care up to 365 days per year — for any person over age 65 on the Welfare rolls. Presently this OAA program covers some 95,000 persons out of a total population of 300,000 people over age 65 in Georgia.

Governor Carl Sanders was the author of the Georgia Kerr-Mills Program, enabling legislation when he served in the Georgia General Assembly. He intimated in his campaign for Governor that *he*

would support the implementation of the MAA part of the Kerr-Mills program. Yet to date there is no indication of action nor was any budget provision made for the MAA part of Kerr-Mills by the 1963 General Assembly. It is interesting to note that five other Southeastern states already have or will have both OAA and MAA in effect by January 1964.

The answer to Social Security health care schemes (King-Anderson type federal legislation) is the Kerr-Mills program of *both OAA for the "needy" and MAA for the "near-needy"* — and voluntary prepaid health insurance for the rest of the aged population. *It is imperative that the MAA portion of Georgia's Kerr-Mills program be started at the earliest possible date.* It is believed that this can be accomplished if the people of Georgia request assistance for the health care of Georgia's "near-needy" aged people.

To achieve this goal of implementing Georgia's MAA program, all physicians are encouraged to let their views be known. Speak up for MAA now — so that Kerr-Mills may function in Georgia as it was designed to do. Certainly the "near-needy" segment of our senior citizens should receive consideration. MAG asks that each physician give this matter his full cooperation to the end that MAA under Kerr-Mills be activated now.

Diagnostic Radiation and Early Pregnancy

THE QUESTION OF EXCESSIVE EXPOSURE of the fetus of early pregnancy to ionizing radiation is a question occasionally brought into focus. The following questions immediately become pertinent: (1) Are we knowingly contributing excessively to the total radiation dosage a fetus receives by imposing no limitation on number or extent of diagnostic X-ray procedures our pregnant patients receive? (2) Are we unwittingly contributing to fetal radiation exposure by routine diagnostic X-ray procedures on women with unsuspected pregnancy? (3) Are we taking the accepted technical precautions that help limit the amount of radiation a given pregnant patient receives during a necessary diagnostic procedure, such as limitation of the X-ray beam with appropriate cones, use of adequate shielding where possible and use of adequate filtration of the X-ray beam? In the answers to these questions lies the principal basis for discussion of this subject.

Increasing Awareness

In the past few years there has been an increasing awareness of the possible genetic effects of excessive ionizing radiation. Not only the medical profession has been concerned with the definition of "excessive," but the laity has been "educated" by various publications, often to the extent of undue alarm. Those properly informed on the subject now know, as a result of continuing assessment of the problem, that the usual medical diagnostic X-ray studies do not constitute undue hazard to the patient or her progeny. Nevertheless, the enhanced sensitivity of developing fetal cells to radiation behooves those of us who use X-ray diagnostically to take special or unusual precautions at times. This is especially true since the background radiation to which all people are exposed has been increasing in recent years and will probably continue to increase with further atomic testing.

Referral Unlikely

The referring physician is not likely to refer a pregnant patient, especially one in early pregnancy, for an extensive series of X-ray procedures. There is always the possibility, however, of having such extensive X-ray procedures ordered on patients with

early and unsuspected pregnancy. There is also the possibility of the physician forgetting momentarily that his patient is, or may be, in early pregnancy. This latter situation might be more apt to occur when X-ray studies are requested by various specialists to whom the patient has been referred for some non-obstetrical reason. The magnitude of these possibilities is not really known, but it should be the province of the referring physician to alert the radiologist in cases of early or "possible" early pregnancy. The referring physician is in the strategic position of being better able both to suspect and diagnose early pregnancy in his candidates for X-ray studies. It is usually impractical for the average radiologist, for example, to delve into the menstrual history of females referred to him for apparently unrelated radiographic procedures. On the other hand, if early pregnancy should evolve as a possibility in the mind of the radiologist when discussing the patient's symptoms, that possibility certainly should be broached with the referring physician.

Specialized Knowledge

Radiologists routinely use their specialized knowledge of ionizing radiation to gain maximum diagnostic information with minimum radiation exposure. Non-radiologists who use diagnostic X-ray to a significant degree, if untrained in the basic physics of ionizing radiation, should feel compelled to acquire sufficient knowledge of ionizing radiation, or obtain adequate consultation, to permit them to gain efficiency in translating their patient's radiation exposure into useful diagnostic information. Routine techniques in radiography can be abbreviated or modified, when indicated, and still yield useful information.

The answer to this problem, if indeed it be a problem, then lies in both the referring physician and the radiologist being ever cognizant of the possibility of early pregnancy in all female patients of child-bearing age. Only by the joint effort of both can absolute minimum exposure to ionizing radiation in early pregnancy be approached.

*George W. Brown, M.D., President,
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PRESIDENT'S LETTER

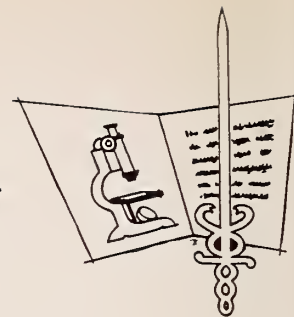


Thomas W. Goodwin, M.D.

"THANKS"

THIS IS MY LAST presidential letter to you. It hardly seems possible that another year could have passed so quickly. This has been a good year for the Medical Association of Georgia. Our fiscal policies remain sound, our committees on the whole have functioned well, and we have met with unusual success with our Legislative programs. We have seen the Kerr-Mills law in Georgia come into successful operation and have been able to expand its benefits. We have been able to greatly increase our liaison with the State Department of Public Health and the State Board of Medical Examiners. We have been able to adequately conduct our educational program for the doctors of the state through the district and local county societies. On the whole we have been able to fulfill adequately the purposes for which the Medical Association of Georgia exists. This, of course, could not have been done by one man and your President claims no credit for what has been accomplished. Instead, let me take this opportunity to give credit to whom credit is due. To all our Officers; Councilors and Vice Councilors; Committee Chairmen and Committee Members; to our efficient Headquarters Office Staff; and to the Officers and Members of the District and County societies. Your response and cooperation and your willingness to work have been most heartening and gratifying. Without it your President could have done nothing. For your support and cooperation, for your effort and your prayers as well as for the honor of serving you, I sincerely say thanks.

Thomas W. Goodwin
President, Medical Association of Georgia



OFFICE CANCER DETECTION CENTER

A. H. Letton, M.D., *Atlanta*

A FEW YEARS AGO it was not too uncommon to find somewhere in many physicians' offices here in Georgia a small plaque or sign that read, "This Office is a Cancer Detection Center."

This was a point of emphasis promoted by the American Cancer Society in its overall program to further educate the American public and assist in increasing professional awareness of early indications of cancer leading to prompt detection and diagnosis. The effectiveness of this program is evidenced in the increasing frequency with which we are now hearing the inquiry, "Do I have Cancer?" and by the improved statistics on earlier detection and cure rates.

Danger Signals Recognized

Although they are still not universally known, the American Cancer Society's Seven Danger Signals are becoming widely recognized by the lay public as possible early signals of malignant tumors, and when they are carefully studied, it is frequently apparent that they are not merely signals to the patient, but actually concise clinical summaries of the major symptoms of cancer in the sites of most frequent occurrence.

They are also, for most practical purposes, the most reliable summary of the fundamentals for planning an adequate "Cancer Detection Program in every Doctor's Office." The crux of the problem of the office examination for carcinoma is to first get the doctors to be constantly "cancer-conscious" in the examination of every patient and then to apply the basic clinical tools available.

A provocative, although possibly unorthodox, approach to "cancer-consciousness" is to think of the disease as follows:

- (1) **VISIBLE:** Skin, Lips, Mouth, Tongue, Vulva, Penis.
- (2) **VISIBLE WITH INSTRUMENTS:** Vagina, Anus, Rectum, Sigmoid, Cervix, Uterus, Urinary Bladder, Larynx, Lungs, Stomach, Esophagus, Nasopharynx.
- (3) **PALPABLE:** Breasts, Rectum, Prostate, Ovaries, Bones, Testes.
- (4) **INACCESSIBLE** — Lungs, Stomach, Intestines, Kidneys, Brain, Bone, and possibly Liver and Pancreas.

It is apparent that in this classification there are overlaps and discrepancies, and it is not intended to imply that there are any short-cuts to diagnosis of cancer. With it we can, however, align with Cancer's Seven Danger Signals these seven principles of office detection of cancer:¹

- A. Patient history — check the seven danger signals.
- B. Complete physical examination with special consideration of the following:
 - (1) Head and neck. Inspect and palpate the head and neck, tongue and oral cavity.
 - (2) Use the laryngeal mirror.
 - (3) Palpate thyroid gland for nodules.
 - (4) Examine breast of every patient.
 - (5) Routinely perform a pelvic examination and make a vaginal smear.
 - (6) Do a rectal examination and make a test for occult blood on a finger specimen of stool.
 - (7) Inspect the entire skin, including vulva, scrotum, soles of feet and palms of hand.
- C. Check hemoglobin — if anemic, look for lesion of gastrointestinal tract.

- D. Do urinalysis — look at sediment.
- E. Obtain X-Ray film of chest.
- F. Perform routine sigmoidoscopic examinations.
- G. Biopsy accessible lesions.

In many cases individual physicians do not have all the instruments necessary nor will he see or feel all the lumps. However, if he thinks along these lines he will see and palpate more lumps and see to it that more diagnostic instruments and procedures are

used. The result will be a "Cancer Detection Center" in every doctor's office, more tumors detected in the early stage and a constantly improving cure rate in cancer patients.

340 Boulevard, N.E.

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Approved by the Professional Education Committee, Georgia Division, ACS.

SOCIETY WARNS OF INCREASING CRIPPLING IN THE UNITED STATES

The problem of crippling in the United States is one of increasing gravity, the National Society for Crippled Children and Adults warned March 6, 1963, with the release of its annual report.

Stepped Up Services

In an effort to keep pace with the steady growth in numbers of the crippled, the Society and its affiliates stepped up rehabilitation services last year to take care of a record patient load—the largest in its 42 year history, the report said. Crippled children and adults treated in the Society's centers totaled 254,913—nearly 12,000 more than in any previous year.

The Society attributes the growing numbers of crippled persons to three factors: normal population growth; larger numbers of accidents, especially those in the home; and medical advances which save victims of formerly fatal crippling diseases.

The Society's annual report, "Panorama of Rehabilitation," detailing its services in 51 states and territories, announced that patients in the more than 1,000 treatment centers and programs of the Easter Seal Society, as the organization is also known, ranged in age from two weeks to 85 years. The largest group under treatment were those with major deformities of bones and joints present at birth or caused by subsequent illnesses or accidents. Other large groups were those with severe speech defects, cerebral palsy, arthritis, muscular dystrophy, multiple sclerosis, poliomyelitis and spina bifida.

Treatment

Rehabilitation treatment given these patients included medical diagnosis, social services, psychological evaluation and counseling, physical, occupation and speech therapy, special education, recreation and camping, vocational services and loan or provision of equipment or appliances. The care was given in treatment and rehabilitation centers, residential and in-patient centers, sheltered workshops, resident and day camps, itinerant and mobile therapy units, diagnostic clinics and many other types of facilities or programs throughout the United States.

In support of its concern over the increasing numbers of crippled and their need for care, the National Society says that there are some 19 million Americans—more than the combined populations of New York, Chicago and Los Angeles—who are so severely crippled that their activities are seriously curtailed. Of this number there are four million so inhibited by their handicaps that, if they are children, they could not attend school or if adults, they could not hold a remunerative job or even undertake the tasks of housekeeping, without rehabilitation treatment.

Major Groups

The report lists the major groups of crippled in the United States as follows: 640,000 with arthritis and rheumatism; 259,000 with loss of one or more limbs; 600,000 with cerebral palsy; 946,000 with complete or partial paralysis; and 6,000,000 with serious speech defects.

Of the patients under care in Easter Seal centers, 79 per cent were children and 21 per cent, adults. More than 33,000 of these patients require extensive physical therapy treatments totaling in the hundreds of thousands and administered only by trained, fully qualified physical therapists on the staffs of Easter Seal Society. Closely following in total demand were occupational therapy, speech therapy and other specialized types of rehabilitation care.

All Easter Seal treatment was given by 2,800 professional staff members. The nation-wide program cost \$19,522,000 during the year, the major share of which was contributed by the public during the Easter Seal Appeal. Total funds retained by the states for direct service programs approximate 95 per cent of gross income.

Education and Research

The report outlines also the educational and research programs of the Society, although stressing that the organization is unique among health agencies in that its major emphasis is on direct patient care and that it is currently caring for more persons than any other national voluntary health agency.



PURE PULMONARY STENOSIS

Hugh K. Sealy, *Macon*

PURE PULMONARY STENOSIS is defined as stenosis of the pulmonary valve with an intact interventricular septum. The stenosis is of two types: the valvular type that results from fusion of the three cusps, producing a dome-shaped valve; and, more rarely, the infundibular type. It was believed formerly that pure pulmonary stenosis was a rare lesion, but since the advent of cardiac catheterization it has been found to be fairly common. One group reports an incidence of 13 per cent in 750 cardiac catheterizations with proven diagnoses. In some individuals there may be a communication between the auricles through the foramen ovale. The elevated pressure in the right auricle forces the valve away from the auricular wall and a right-to-left shunt results. The disturbances in cardiac function are due to the obstruction to flow from the right ventricle into the pulmonary artery. This produces an increase in the right ventricular and auricular pressure and right ventricular hypertrophy. The circulation to the lung is slowed and the circulation in general is also slowed. It is believed that the valve orifice does not increase with age. Cyanosis occurs in some individuals as a result of the right to left shunt and also rarely the "peripheral cyanosis" which results from increased oxygen extraction because of the decreased cardiac output.

Major Complaints

The major complaints of the patients are dyspnea and fatigue. The severity of the symptoms is dependent upon the degree of obstruction. Symptoms in many do not occur until late childhood or early adulthood because the valve orifice may be large enough to permit adequate flow of blood in the child but the small opening would be inadequate for a larger person. The dyspnea and fatigue are due to the inability of the heart to pump blood past

the obstruction. Squatting is rare but may occur. There is usually no effect on the growth of the individual. Cyanosis is rarely present at birth but occasionally develops later in life. Clubbing is also rare. Sometimes the neck veins are distended and show a prominent A wave. A systolic murmur at the base of the heart to the left of the sternum is the most consistent physical finding. The murmur is accompanied by a thrill in the suprasternal notch. The murmur is transmitted to the neck and back. The pulmonary second sound is absent or markedly diminished. A diastolic murmur has been described and attributed by some to valvular incompetency associated with the stenosis but is probably due to the systolic murmur extending beyond the faint second sound. Absence of the thrill and presence of the second sound indicates the lesion is infundibular in location.

Type of Failure

The heart failure that develops is right sided and is accompanied by ascites, edema and hepatomegaly. Pulsations of the liver occur. The lungs are free of edema.

Post stenotic dilation of the pulmonary artery is present in over two-thirds of the cases. The artery may be dilated almost to aneurysmal proportions and this can occur with a normal sized heart. This finding on a routine chest X-ray may be an early indication of the disease. The heart size varies and if there is any enlargement it is of the right auricle and ventricle. The left ventricle and auricle are never enlarged. The pulmonary vasculature and secondary pulsations are decreased. The electrocardiographic changes also show evidence of right sided enlargement. The abnormality may vary from right axis deviation to incomplete right bundle branch block and to right ventricular hypertrophy and strain. The changes of strain and hypertrophy are frequently

the earliest signs that a critical point is about to be reached in the patient's illness. Because of this the electrocardiogram is one of the best and simplest methods of following the patient's course.

Findings

The findings on cardiac catheterization are those of obstruction to flow from the right ventricle, increased pressure in the right auricle and ventricle with a pressure gradient on passing the catheter into the pulmonary artery. Other catheter findings are a normal pulmonary capillary pressure, atrial shunt when present, and diminished cardiac output. Angiocardiology may be of some help in determining the location of the lesion. Those patients may be divided into three groups based on severity of the lesion. The mild group has no symptoms and the diagnosis is made only because of the presence of a murmur since birth. The moderate group has progressive symptoms starting in childhood. These people should be followed closely to determine if treatment is indicated and when it should be done. The more severe group begins to have difficulty in infancy and surgical intervention is necessary during infancy if they are to survive.

Treatment of the lesion is surgical but is done only in those who have evidence of a failing right ventricle. Most authorities agree that those patients with

a right ventricular pressure below 80 mm Mercury do not require surgery but that surgery is indicated in individuals with pressures above 100. The electrocardiogram will practically always show right ventricular hypertrophy and strain when the pressure is 100 or greater. The first surgical procedure was the Brock procedure which was closed resection of the valve. For obvious reasons this procedure was not entirely satisfactory. Now the procedure of choice is direct approach with hypothermia and extracorporeal circulation. Under these conditions the fused valve leaflets can be separated and the infundibular lesion, if present, also resected. The results with this procedure are very good particularly in those with the valvular lesion.

Summary

In summary, pure pulmonary stenosis is either stenosis of the valve or infundibular stenosis without a defect in the interventricular septum. A systolic murmur at the base of the heart to the left of the sternum, post stenotic dilation of the pulmonary artery and evidence of diminished pulmonary blood flow on X-ray and right ventricular enlargement by EKG are the diagnostic points. Treatment is surgical resection in those individuals having evidence of a failing right ventricle.

765 Spring Street

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

TB ASSOCIATIONS TO LAUNCH EDUCATIONAL CAMPAIGN

Tuberculosis Associations throughout the United States will launch a major educational effort on May 1st on early symptoms of respiratory diseases. Scheduled to run through June 15, the effort will have a single message: "If you have a chronic cough or shortness of breath, don't take chances with respiratory diseases. See your doctor!"

Chronic cough or shortness of breath are the two most common symptoms of chronic respiratory diseases. They are so common that too many people take them for granted and are unaware of their serious implications.

To aid physicians, the American Thoracic Society, the medical section of the National Tuberculosis Association, has prepared a booklet, "Chronic Cough or Shortness of Breath . . . Differential Diagnosis." As a part of the educational campaign, every physician in Georgia will be provided a copy of the booklet by their tuberculosis association. A quote from this guide says: "Physicians cannot ignore the symptoms of chronic cough or shortness of breath, or let time uncover their causes. These two symptoms can hide many diseases . . . some of them extremely serious and calling for immediate treatment.

"The diagnostic problem presented to the physician by chronic cough and shortness of breath is by no means simple. And there is no simple solution for it. The fact

is that chronic cough and shortness of breath . . . for all their commonness and frequency . . . can be serious.

"They may be symptoms of all these diseases: Hyperventilation syndrome, Bronchitis, Bronchiectasis, Emphysema, Asthma, Loeffler's syndrome, Sarcoidosis, Berylliosis, Pneumoconiosis, Silicosis, Asbestosis, Pulmonary fibrosis, Wegner's granulomatosis, Tuberculosis, Histoplasmosis, Coccidioidomycosis, Granulomas, Benign tumors, Malignant tumors, Chronic pneumonias, Pulmonary infarction, Cysts, Bullae, Heart disease—congenital, rheumatic, arteriosclerotic, cor-pulmonale, Pulmonary edema. Only a systematic diagnosis can decide which.

"These diseases may have no common denominator except chronic cough and shortness of breath. But the two symptoms are common to all respiratory diseases and therefore of vital importance in the control of these diseases. That is why a routine procedure for diagnosing chronic cough and shortness of breath can be so valuable to every practicing physician, who accepts his responsibility to protect the health of his patient."

In addition to the special information for physicians, TB associations will attempt to alert the public to the symptoms of early respiratory diseases through speakers, film showings, literature distribution, medical education programs, meetings, posters, billboards, car cards, radio and TV announcements, and newspaper articles.



PROBLEMS OF THE AVERAGE COLLEGE STUDENT

George M. Lott, M.D., *State College, Pennsylvania*

COLLEGE OR UNIVERSITY students enthuse over many new experiences. There are many new joys as well as problems. Homesickness for the Freshmen may temporarily handicap but usually not for long.¹

When, as is usually the case, some difficulties arise, they include restlessness, poor concentration, sleep disturbances, and poor marks. There may be anxieties, fears and even stomach pains or headaches. Some six common basic problems can usually be uncovered either singly or in combination along with varieties of immaturities, childish dependencies and lack of developed sense of responsibility.

Course Too Difficult

First, there are those who have chosen a type of course that is over their heads. They are the students who had to study hard in high school to keep up. The first few semesters in college, their courses are studded with failures or near failures. Then they develop fatigue symptoms and depressions. Pressing, drawing headaches and shifting pains may alarm them. They have to be advised to take up simpler or shorter courses because they are not intellectually able enough to keep up with their contemporaries in the harder courses. Many of this group are helped by a course in reading skills, especially the slow readers who fall behind.

There is another group whose parents have always wanted them to excel. These young people, being dutiful, start out by turning in a creditable performance in high school, but the parents are very lukewarm when they receive only C's and a few B's. The next year they work harder and get B's and a few A's. The parents are pleased, but feel that they should be critical in order to spur the children to

greater effort. Finally, the children bring home all A's, with perhaps one B. One particular father, however, wanted perfection and would say to his children, "I think you can do better than that." Actually these young people have always succeeded, but have acquired the impression that they have failed. They have paralyzing feelings of inferiority, which are a great handicap.

The "Detailists"

Third, there are the students whom we might call the "detailists." They can't see the woods for the trees. I have in mind a boy who was raised very strictly and who became very dutiful and perfectionistic. He tried to do everything in the manual. In his first year, he had only two major subjects and had time to learn every little detail in his assignments. The next year, in a larger college, he attempted to be as thorough with five major courses. Even the bright students had only time enough to attempt one problem of each type. Soon he was floundering away behind and developed a fatigue state, with headaches and stomach pains. He had to drop out of school for a while to recover and to learn to pick out what was important from what was not. The drive for perfection can become a handicap.

It is difficult to remedy such personality problems, and a great deal of guidance and help are needed.

The Brilliant Students

There is a fourth group—the brilliant students who, with no special effort, have been on the honor rolls in high schools. Our college populations are largely drawn from this upper two-fifths of high-school graduation classes. Many could listen in class and learn enough without even "cracking a book."

They had never had to develop steady habits of application. They come to college and have more competition and more complicated studies. If they don't rapidly learn to apply themselves, they show up poorly, because colleges are for the most part full of high school honor students.

These students with superior intellects, who have never been challenged, do no better than those of mediocre ability with good work habits. Frequently they do less well and become drifters. They say, "The professor does not make the course interesting," or, "I just can't get down to studying." A book is started, but not finished, unless it is especially intriguing. They usually blame the mediocre marks on something else. There are the fritterers, wasting time. They carry five courses—that is, they carry one or two and drag the rest. They sometimes seek psychiatric assistance and have to realize that if they drift along, they will come out at the bottom. The ability to get down and plug has to be developed. At first many are unwilling, almost insulted, that so much effort has to be made.

Potentials

These students are the potential leaders of the nation. Because their brilliant capacities are not challenged in their formative years, too many become mediocrities. The most efficient remedy probably lies back in the junior and senior high schools. An enriched course of study and balanced, progressive methods of teaching can better prepare them for higher learning.

Fifth, there are capable young people who suffer from anxiety states and "blow-up" during examina-

tions. Fear of tests seems to afflict most students and is probably an occupational disease. For some, tests are nightmares. One young woman would study hard and know her subject, but blow up in a panic during the examination. This anxiety was traced back to many hidden unsolved childhood problems. One reason why the anxiety focused on final examinations was a long standing fear of being unable to please a severe school principal, her father.

Compulsive Psychoneuroses

Sixth, there are the more severe obsessive or compulsive psychoneuroses. One young man could not do the courses in science without repeated mistakes and becoming much disturbed. It was found that he had a compliant passive father who said little. His stronger mother had in some way become confused with science and the youth's revolt to her unstabilized his learning. Finally, after months of psychotherapy, he was able to correct childhood misunderstandings and was freer to progress in his studies.

Psychotic breakdowns are relatively rare.

We may say that among the main common clinical problems in college students are the intellectually incompetent, the self-distrustful, the detailists, the frustrated perfectionists, the fritterers, the blow-ups, and those who suffer from anxiety states and serious psychoneuroses.

617 East Foster Avenue

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Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

BISHOP SHEEN TO DISCUSS DOCTOR-CLERGY RELATIONS AT AMA CONVENTION

An interesting new program feature of the American Medical Association's 112th annual meeting June 16-20 at Atlantic City will be a session on relationship between physicians and clergymen.

The program, first of its kind ever held on a national level, was developed by the AMA's newly formed Committee on Medicine and Religion. Milford O. Rouse, M.D., of Dallas, is chairman. The session will be held on the opening day, Sunday, June 16, at 8 p.m. in the City Auditorium.

Featured speakers will be The most Rev. Fulton J. Sheen, Catholic Bishop of New York and a TV personality, and Edward R. Rynearson, M.D., of the Mayo Clinic, Rochester, Minn. Dr. Rynearson appeared before the AMA annual meeting last year in Chicago. He

questioned the use of extreme measures in prolonging the life of terminal cancer patients.

"The ill person often is more than physically ill," Dr. Rouse said. "He is—at least to a degree—also mentally, spiritually and socially ill at the same time. All of these aspects must be considered in treatment.

"Often the physician and the clergyman can help each other in dealing with the patient or his family in cases of serious illness," Dr. Rouse said.

The Rev. Dr. Paul B. McCleave, Chicago, director of the AMA's Department of Medicine and Religion, said the program is the result of a mutual exchange of information between medicine and the clergy at the local medical society level throughout the country.



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Moseley, Herbert F., M.D., *ACCIDENT SURGERY*, Appleton-Century-Crofts, New York, 1963, 242, pp. \$10.00.

Flood, Frank B., M.D.; Kennedy, Richard J., M.D.; Grace, William J., M.D., *MEDICAL RESIDENT'S MANUAL*, Appleton-Century-Crofts, New York, 1962, 311 pp.

The mystery about this clever handbook is that someone didn't publish it years ago. As the authors note, it is the outgrowth of many residents' notebooks, the . . . "private medical text in which he notes clinical pearls, rules of thumb, diagnostic clues, seldom used and easily forgotten procedures that are of importance in emergencies, dosage of drugs, key references, summaries of his reading, and many unanswered questions that arise during his busy days." Contained in this handbook is a solid collection of just such "little nuggets." Many diverse clinical topics are systematically arranged and described succinctly without sacrifice of substance, so that the "many unanswered questions" are answered comprehensively and clearly. The book makes available differential diagnoses which suggest clues to further evaluation of laboratory findings or symptoms. Clinical conditions are reviewed briefly; history, physical findings, differential diagnosis, course and treatment outlined. Each section is followed by one or more recent references and actually forms a survey of many recent developments in clinical medicine and pharmacology. The information about electrocardiograms is detailed to an extent beyond that expected in a handbook, forming a more than adequate review of the subject.

This book is recommended to busy practitioners as well as to those in training.

Donald P. Harris, M.D.

Robbins, Stanley L., M.D., *TEXTBOOK OF PATHOLOGY WITH CLINICAL APPLICATION*, Second Edition, W. B. Saunders and Co., Philadelphia and London, 1962.

The author and contributors have succeeded in incorporating the new body of knowledge of the inter-

vening years without losing the effectiveness of the first edition. The bibliography reflects sound judgment in the old that is retained and the new that is added, with the result a most satisfactory one. The major subjects are treated in the time honored logical sequence of etiology, pathogenesis, gross and microscopic anatomy, with adequate illustrations; but the attractive feature is still the inclusion of a section usually designated "Clinical Course" in which a correlation is given where there is justification, but at no time is correlation forced. As a matter of fact, the particular value of this text is the generally successful attempt to point out clearly those conditions in which the pathological anatomical findings are diagnostic, those in which they are present but non-specific, and those in which an anatomical equivalent is lacking. There are valuable sections that put the diagnostic possibilities of pathological anatomy in proper perspective. For example, in the chapter on blood, the limitations and value of biopsy of bone marrow in blood dyscrasias are clearly and succinctly given.

This is a very useful textbook for the teacher and student, as well as for the clinician.

Darrell Ayer, M.D.

Marti-Ibanez, Felix, M.D., *THE EPIC OF MEDICINE*, MD Publications, Inc., New York, 1962.

Before sunrise of the first civilization, in the long, primordial rehearsal, the first physician was born. With little more than his hands, early man developed techniques that were magical art and pseudo science. But then there developed in the land of Egypt and in the valley of the Tigris-Euphrates, civilizations which aided the progress of medicine unlike any peoples before. The unique feature of this volume is the style which has been used to direct into the main stream of medical history the eddies of each age. The relationship of less significant events of one age to another and their combined relationship with the main stream is well presented. From the Egyptian Imhotep to the Virologist Jonas Salk, Marti-Ibanez has joined with his colleagues to produce a vibrant, pulsating manuscript that combines in one beautifully illustrated volume the important contributions of man to the main stream of medical history.

The Shaman of prehistoric medical magic is used in both his primordial and contemporary environments. By relating medical history to the cultural disciplines of poetry, painting and prose as well as to contemporary scientific disciplines, the weighty aspects of the conventional history book are avoided.

The format is inviting. Reader curiosity is aroused by bits of clever journalism illustrated best by the pleasant surprise of finding on a single page (239) a discussion of pathology and contemporary art. Edouard Manet's classic "Boating," reflects the editor's desire to instill life into a history book that would otherwise be dull indeed if the illustrations were confined to illustrations of scientific events.

Not content to report historical fact, the editor and his colleagues, aware of their vast audience of physicians, have successfully interpreted the significance of the contributions of each age. The follies of the past and the glories lead to a continuation of the unbroken tradition of man helping man in a profession unlike all others with a sense of dedication, supported by numerous sciences and technology. The bibliography is voluminous but is well organized and related to each chapter. The index is especially useful for the student who would add the volume to his reference library.

Peter L. Scardino, M.D.

Currie, Alastair, R.; Symington, T.; and Grant, J. K., **THE HUMAN ADRENAL CORTEX**, The Williams and Wilkins Company, Baltimore, 1962, 644 pp., \$11.00.

For some years there has been a need for a comprehensive book dealing with the adrenal cortex. This book partially fills that need. *The Human Adrenal Cortex* is divided into six parts: discussions of morphology, biochemistry of the adrenocortical hormones, control of adrenocortical secretion, metabolic effects of adrenocortical hormones, disease of the adrenal cortex and the physiology of the foetal adrenal cortex.

The section on disease of the adrenal cortex will be of greatest interest to the practicing physician. The discussion is centered around diseases of adrenal cortical excess and takes up in detail the syndromes of virilizing adrenal hyperplasia, Cushing's Syndrome and primary hyperaldosteronism. In each instance excellent basic physiologic discussions are offered and clear definitive clinical observations are made.

The practitioner will enjoy reading sections of the remainder of the book but will find that this material applies to his clinical work in a very limited degree.

The Human Adrenal Cortex represents the edited presentations of a variety of workers of a conference held at the University of Glasgow, July 1960. This format, which by now has become familiar, has several serious deficiencies. The foremost deficiency is the incomplete coverage of the subject. Another deficiency is the extensive discussion of minor consideration. For example, in the section on metabolic effects of the hormones, Solomon and Sayers, discussed the profusion of the isolated rat heart lung with adrenocortical steroids. While of some interest, this is a very narrow facet of adrenocortical physiology.

A very powerful positive consideration for the presentation is the fact that the reader is allowed to have access to the most recent thoughts of nearly every prominent student of the adrenal cortex in the Free World. It is also fun to thumb through the book and see the "finger-prints" of the various workers. Their personalities show through in the phraseology, design of the experiment, presentation of the data in charts and in graphs. This is frequently a very pleasant extra dividend.

Roy A. Wiggins, Jr., M.D.

Engel, George L., M.D., **PSYCHOLOGICAL DEVELOPMENT IN HEALTH AND DISEASE**, W. B. Saunders Co., Philadelphia, 1962.

Ambivalence best describes this reviewer's reaction to this text. There has been a long-standing need for a

basic book dealing with the psychology and pathology of psychological development. Accordingly, the arrival of Dr. Engel's book was greeted with enthusiasm. It was then perused with interest and pored over with some pleasure and a modicum of disappointment.

For many years Dr. Engel has lectured to sophomore medical students on the vagaries of psychological development. Each of the 34 chapters is an expansion of one of his two-hour weekly lectures. Taken at such a slow pace, with ample opportunity for re-reading and witnessing clinical demonstrations, this text should be extremely rewarding provided the instructor subscribes to the classical analytic doctrines, as does the author. It is just this emphasis on analytic jargon that seriously limits the effectiveness of the book. The non-psychiatrist is apt to find himself hopelessly bogged down in some of the chapters, such as those on the mental apparatus. Paradoxically, many of the other chapters, written with a less heavy hand, are gems of psychodynamic description (c.f. the chapter on grief and mourning).

In short, this basically good book, emphasizing normative development and the correlation of psychological and physiological phenomena, is designed for the student with time and instructors at his disposal, or the physician who already has more than a passing acquaintance with psychiatry.

Sheldon B. Cohen, M.D.

Parsons, Langdon, M.D., and Sommers, Sheldon C., M.D., **GYNECOLOGY**, W. B. Saunders Company, Philadelphia, 1962, 1,250 pp., \$20.00.

Dr. Parsons, a gynecologic clinician, and Dr. Sommers, a general pathologist with a vast experience in gynecologic pathology, have collaborated to make this probably the best gynecology book yet published.

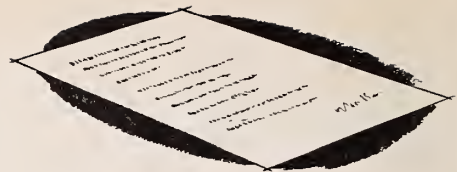
An interesting feature of this text is the new concept which the authors have in dividing the subject of gynecology into age groups rather than into the conventional divisions according to particular disease processes or disorders. With this unique approach, the gynecologic problems encountered in each of the roughly seven decades of a woman's life, namely, the periods of growth, development, maturation, maturity, senescence, and senility, are discussed in a most enlightening and interesting style. Each problem is included in the age division where it is most commonly encountered. Illustrations are excellent and abundant. Comprehensive sections on gynecology in the infant and in the geriatric patient are included in this volume; these particular subjects have to a certain extent been slighted, or at best incompletely covered in earlier published texts.

Formal sections dealing with female anatomy and embryology have been wisely omitted by the authors. Detailed descriptions of operative procedures were also considered outside the scope of this book. These omissions have added considerably to the ease with which this work can be read.

This great book should prove most useful to the medical student and general practitioners as well as to the practicing gynecologist.

William C. Helms, M.D.

ABSTRACTS BY GEORGIA AUTHORS



Martin, J. D., Jr., M.D., and Amerson, J. Richard, M.D., Emory Hospital, Atlanta 22, Georgia, "Adrenal Cysts," *Am. Surgeon* 29:52-55 (January) 63.

Benign adrenal cysts occur infrequently. During the past 30 years, 61 cases have been reported in the American literature. The experience with two additional cases has been summarized and reported.

In four cases reported has endocrine malfunction been associated with adrenal cysts. The lesion is predominantly unilateral, occurs more frequently in females, and has been encountered most frequently in patients between the ages of 30 and 60 years.

The etiology is obscure. A recent classification includes 1) parasitic cysts, 2) congenital glandular (retention) cysts, 3) cystic adenoma, 4) endothe-
lial cysts (lymphangiomatous and angio-
matous), and 5) pseudocysts. Pseudo-
cysts are by far the most common. The
cysts are usually discovered as inciden-
tal findings and are rarely diagnosed
preoperatively.

Symptoms develop primarily when the cyst enlarges sufficiently to exert pressure on neighboring organs. Since the cysts may become quite large, in many instances the lesions can be palpated. An excretory or retrograde urogram provides the most helpful information. Calcification, seen most frequently in the pseudocysts, can readily be seen on roentgenograms and is a great aid in diagnosis.

Treatment consists of complete excision of the cyst and gland without disturbing the kidney. Both patients in this report did well, and in only one of the reported cases was there adrenal insufficiency following excision of the cyst and the involved adrenal gland.

Brown, Robert L., M.D., Emory Hospital, Atlanta 22, Georgia, "The Objectives of the American Radium Society," *Am. J. Roentgenol.* 89:3-5 (January) 63.

The American Radium Society was organized on October 26, 1916. The founding group included surgeons, radiologists, dermatologists, internists and a physicist. From the very beginning the American Radium Society has included in its membership, representatives from various specialties drawn together by a common interest which is the study of malignant disease and the agents most effective in its treatment with particular attention to radium, X-ray and other sources of ionizing radiation. The original objective of the American Radium Society, "To promote the scientific study of radium in relation to its physical properties and its therapeutic application," has been broadened so that the statement of objectives in the constitution of the Society now reads, "The objectives of the Society shall be to promote the scientific study of radium and other sources of ionizing

radiation to their physical properties, their biological effects and their therapeutic application; and to encourage liaison between the various specialties concerned with the treatment of cancer." Membership in the Society offers an unusual opportunity for qualified radiologists, surgeons, internists, hematologists, pathologists, dermatologists, pediatricians and physicists to meet together for consideration of problems related to the diagnosis and treatment of cancer.

Dobes, William L., M.D., 478 Peachtree Street, N.E., Atlanta 8, Georgia, "The Use of Folic Acid Antagonists and Steroids in Treatment of Psoriasis," *South. M.J.* 56:187-192 (February) 63.

The chronicity and resistance to treatment of psoriasis makes continued research relative to its cause and its management mandatory. The etiology may be faulty metabolism of sulfur in the skin. The results of therapy with antimetabolites and steroids are given. This combined treatment is very effective in a high percentage of generalized and treatment-resistant cases. The antimetabolite dosage must be minimal. The Triamcinolone dosage should be moderate with decreasing amounts given over a one to two week period. Triamcinolone is most effective, but in large doses or in prolonged treatment may cause a rebound of the psoriatic process and eventually cause more harm than good. The combination treatment, in the author's opinion, is safe and reliable, but should be used only by those who are well acquainted with the chemistry, reactions and potential dangers of the drugs. The dosages, side effects and results of treatment are discussed in detail.

Logan, William D., Jr., M.D.; Pausa, Sergio G., M.D.; and Crispin, Roy H., M.D., Georgia Baptist Hospital, Atlanta, Georgia, "Spontaneous Pneumothorax of the Newborn," *Dis. of Chest* 42:611-614 (December) 62.

Spontaneous pneumothorax occurs infrequently as a symptomatic condition in the neonatal period. There is considerable variation in the reported incidence of spontaneous pneumothorax in the newborn. This is a review of known cases from Georgia Baptist Hospital and Crawford W. Long Hospital in Atlanta, during an 11-year-period in which there were approximately 50,000 live births. There was a total of eight known cases. These were summarized. There was equal sex incidence and all had evidence of respiratory difficulty within the first 48 hours of life. Definite diagnosis is made by roentgenograms. Once the diagnosis has been established, treatment varies with the extent of pneumothorax. If it is unilateral and less than 25 per cent, needle aspiration and careful observation should be carried out. For those cases with more

than 25 per cent pneumothorax, thoracotomy tube drainage is usually indicated. There was one death in this group of eight patients. Prompt recognition and treatment is necessary and can be life-saving.

Dominguez, Herman, M.D. Simowitz, Fred, M.D.; and Greenblatt, Robert B., M.D., Medical College of Georgia, Augusta, Georgia, "Clinical Evaluation of a New Oral Progestin-Chlormadinone," *Am. J. Obst.* 84:1478-1486 (December) 62.

A new oral progestational agent, 6-chloro-6-dehydro-17-alpha-acetoxypregesterone (chlormadinone) was subjected to clinical evaluation. In the treatment of functional uterine bleeding it was found that six to eight mg. of chlormadinone with 0.18 to 0.24 mg. of 3-methyl ether of ethinyl estradiol (EE3ME) for five to ten days was adequate to arrest successfully bleeding in almost every instance. Failure occurred either on smaller dosage or when estrogen was not administered with the progestational agent. Chlormadinone succeeded in inducing withdrawal bleeding in 162 of 165 trials in patients complaining of amenorrhea. The average dose was two mg. daily for five days. Chlormadinone was effective in delaying menses in doses from four to six mg. when EE3ME was added in doses of 0.12 to 0.18 mg.

Milligram for milligram, chlormadinone appears to be more potent than other derivatives of acetoxypregesterone thus far assayed. If an adequate dosage of any good progestogen is used, the dosage per se is of little consequence.

Merselis, John G., Jr., M.D., New York; Sellers, Thomas F., M.D., 5445 Trimble Road, N.E., Atlanta, Georgia; Johnson, Joseph E., M.D., Baltimore, Maryland; and Hook, Edward W., M.D., New York, "Hemophilus Influenzae Meningitis in Adults," *Arch. Int. Med.* 110:837-846 (December) 62.

Despite the frequent occurrence of *H. influenzae* meningitis in children, this type of infection is remarkably rare in adults. The present report adds 11 additional cases to some 44 previously reported. The clinical manifestations of this infection are similar to those of other types of bacterial meningitis, and because of its rarity may not be thought of in an adult patient. Moreover, in the examination of spinal fluid smears, the pleomorphic rods may easily be mistaken for pneumococci or meningococci. This infection is often associated with some other condition which impairs host resistance and its occurrence in adults should stimulate investigation to defect such processes as cerebrospinal rhinorrhea, agammaglobulinemia, diabetes mellitus, or alcoholism.

Wood, J. Edwin, M.D., Medical College of Georgia, Augusta, Georgia, "The Mechanism of the Increased Venous Pressure with Exercise in Congestive Heart Failure," J. Clin. Inves. 41:2020-2024 (November) 62.

The peripheral venomotor and venous pressure responses to exercise of patients with congestive heart failure were studied. Venous distensibility of the forearm was measured with a plethysmograph during exercise of the legs. Constriction of the veins and a concomitant rise of venous pressure occurred with exercise in these patients. The responses to exercise were interrupted by a sympathetic ganglioplegic agent. Forearm venoconstriction occurred despite arterial occlusion of the exercising legs. The venoconstrictor response to the same exercise was not observed in compensated patients.

These experiments lead to the hypothesis that in congestive heart failure excessive venous pressure during exer-

tion occurs primarily as a result of constriction of the veins. This constriction of veins is mediated by a sympatho-adrenal discharge. These results are opposed to the concept that excessive flow of blood into the venous system with inadequate removal of this blood by the handicapped heart results in elevated blood pressure within the veins.

Wood, J. Edwin, M.D., Medical College of Georgia, Augusta, Georgia, "Angiotensin," Heart Bull. 12:5-7 (January-February) 63.

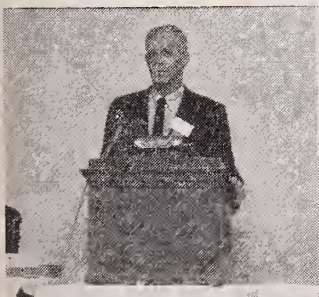
Angiotensin has recently been made available to investigators in the synthetic form and as a result much interest has been generated in this small polypeptide. The renin-angiotensin system appears to have some importance not only in the normal control of blood pressure but in the production of essential hypertension and of hypertension due to unilateral renal vascular disease.

This material in its naturally occurring state also serves to control aldosterone secretion. Synthetic angiotensin likewise will result in release of aldosterone from the adrenal gland.

Synthetic angiotensin is now supplied as a white powder (Hypertensin-Ciba) for the treatment of shock. It is the most potent vasoconstrictor yet discovered. This material may be given subcutaneously in emergency situations when no vein can be found to administer it intravenously which is the normal route of use. Sloughing of tissues will not occur. Arrhythmias are minimal with use of this drug. Additionally, angiotensin has a minimal veno-constricting effect so that in circumstances such as shock associated with congestive heart failure in myocardial infarction, it would appear that angiotensin would offer a useful way of raising arterial pressure with a minimal effect on venous pressure.

COUNTY SOCIETY OFFICERS CONFERENCE HIGHLIGHTS YOUTH FITNESS, GAMPAC

Over 100 of Georgia's County Medical Society Officers convened in Atlanta March 2 and 3, 1963, for the Fifth Annual Meeting. Highlighting the conference's



Mr. Charles "Bud" Wilkinson

featured program of "Youth Fitness for 1963," and "Politics and Medicine in '63," were Mr. Charles "Bud" Wilkinson, Norman, Oklahoma, Consultant for the President on Youth Fitness and Athletic Director at the University of Oklahoma; and Dr. Milton

Davis, Dallas, Texas, 1962 Secretary-Treasurer of the American Medical Political Action Committee.

In addition to the featured guests, several other eminent personalities contributed their views to the youth fitness program. Serving on a panel, "Youth Fitness Leadership for Your Community," moderated by Dr. Fred Allman, Jr., Atlanta, Chairman of the Fulton County Medical Society Athletic Injury Committee, were John W. Letson, Superintendent of Atlanta Public Schools; Oliver Hunnicutt, Director of LaGrange High School Athletics; Maxie Baughn, Director, Covington Boy Scout Camp and a member of the Philadelphia Eagles Football Team; Cobern Kelley, Physical Director, Athens Y.M.C.A.; Dick Lane, Superintendent, East Point Park and Recreation Department; and Thomas E. McDonough, Sr., Chairman, Division of Physical Education and Athletics, Emory University.

Following up Mr. Wilkinson's ideas on physical fitness was the talk given by Mr. Hugh "Duffy" Daugherty, speaking on, "The Importance of Competitive Athletics." Mr. Daugherty is Head Football Coach at Michigan State University.

"Politics and Medicine" was the featured topic at the Sunday meeting held in the MAG Headquarters Building. "The Congressional Picture for 1963," was the subject chosen by Dr. Durward Hall, Member of Congress, Springfield, Missouri. Dr. John T. Mauldin, Medical Director, Adult Recipients Programs; and Mr. Sheffield Owen, Chairman of the Health Insurance Council of Georgia, discussed, "Kerr-Mills and Voluntary Prepaid Health Insurance." Speaking in place of Mr. Aubrey D. Gates, Director AMA Division of Field Service, who was unable to attend the meeting, was Mr. Richard Nelson, AMA Field Representative, whose topic was, "Winning Friends and Influencing Congress." Dr. Milton Davis, and Dr. Milford B. Hatcher, Chairman of GaMPAC, spoke on the goals for AMPAC and GaMPAC. Dr. J. Frank Walker, AMA Council on Legislative Activities, closed the program with a "Legislative Wrap-up Resume."



Left to right: Dr. John Letson, Mr. Oliver Hunnicutt, Mr. Dick Lane, Dr. Fred Allman, Jr., Mr. Cobern Kelley, and Mr. Maxie Baughn.

THE ASSOCIATION



DEATHS

M. B. COPELOFF, 69, of Atlanta, died at his home February 12, 1963. Dr. Copeloff was Medical Director of the Atlanta Jewish Home, a physician at the Confederate Home and the Georgia Training School for Girls, and was a member of the Governor's Medical Staff.

Born in Atlanta, Dr. Copeloff spent his early life in Mississippi, but returned to Atlanta to attend Emory University School of Medicine. He had practiced in the city for 45 years.

He was a member of the Fulton County Medical Society, the Medical Association of Georgia, AMA, Ahavath Achim Synagogue, Fulton Masonic Lodge, and the Shrine.

Surviving are his wife, Millie Harris; and two daughters, Mrs. Harold Allman, and Mrs. Sanford Shmerling, both of Atlanta.

SOCIETIES

On February 5, 1963, the annual Whitman Memorial Lecture was delivered by Dr. Wilbur N. Tauxe of the Mayo Clinic, to the BIBB COUNTY MEDICAL SOCIETY. Dr. Tauxe's subject was, "Clinical Application of the Use of Isotopes."

CARROLL - DOUGLAS - HARALSON MEDICAL SOCIETY met March 8, 1963, at Bowdon and had as program speaker Thomas E. Reeve, Jr., of Carrollton. Dr. Reeve presented several case histories and a discussion on the topic, "Incarcerated Femoral Hernia."

Robert Gibbs, a specialist in internal medicine, has been installed as President of the DeKALB COUNTY MEDICAL SOCIETY. Dr. Gibbs succeeds John Trotter.

Other officers installed at the February meeting were Howard Lee, President-elect; and Earnest Atkins, Secretary. Lee does general practice and surgery in Decatur, and Dr. Atkins practices general surgery. He is associated with the Toco Hills Clinic.

At the recent Albany meeting of the DOUGHERTY COUNTY MEDICAL SOCIETY the following officers were elected for 1963: T. D. Johnson, President; P. E. Findlay, Vice President; and Abram Goldsmith, Secretary-Treasurer.

The delegates elected to the Medical Association of Georgia were: W. F. McKemie, W. P. Rhyne, and alternate, Ben I. Giles.

Herbert Karp, Neurologist at Emory University Hospital, conducted a clinic on historical and physical examination of the patient with a neurological disorder. He then presented a discussion of the various aspects of convulsive disorders which was followed by a question and answer period.

GEORGIA MEDICAL SOCIETY met March 12, 1963, at Savannah. Dr. Marvin Boris, United States Public Health Service, Epidemiology Branch, spoke on, "Inoculation of New-born with Staphylococcus."

Robert L. Bennett, Executive Director of the Georgia Warm Springs Foundation, spoke to the MUSCOGEE COUNTY MEDICAL SOCIETY at its recent meeting in Columbus. Dr. Bennett's subject concerned the arthritic patient.

Earl A. Mayo of Richland was elected President of the RANDOLPH-TERRELL COUNTY MEDICAL SOCIETY at the recent meeting in Richland. Other officers include Walter D. Martin of Cuthbert, Vice President; Carl E. Sills of Cuthbert, Secretary-Treasurer; Robert B. Martin of Dawson, Charles M. Ward of Cuthbert and C. M. Pugh of Lumpkin, censors.

Members decided that meeting places will rotate among Cuthbert, Richland and Dawson.

SOUTHWEST GEORGIA MEDICAL SOCIETY, together with the Woman's Auxiliary, held their regular bi-monthly meeting January 22, in Blakely. The following officers for 1963 were announced: H. L. Lassiter, Arlington, President; James P. Lyons, Edison, Vice President; and R. E. Jennings, Arlington, Secretary-Treasurer. J. Dan Bateman, Albany, presented the scientific program. His subject was, "The Acute Gall Bladder."

February 3, 1963, in Griffin, SPALDING COUNTY MEDICAL SOCIETY had as its guest speaker, Dr. Glenn McCormick, Dermatologist, Emory University, who spoke on, "Diagnosis and Treatment of Common Dermatoses in Office Practice."

SUMTER COUNTY MEDICAL SOCIETY recently sponsored a Public Forum on Heart Disorders at Georgia Southwestern College in Americus. Dr. Charles Hollis, Albany, was the guest speaker. His topic concerned, "Arteriosclerosis and Coronary Disease." After Dr. Hollis' presentation, he joined a panel composed of Dr. R. A. Collins, Jr., Americus and Dr. Frank Wilson, Leslie. Dr. William Anderson, President of the medical society served as a moderator. The forum, conducted especially for the lay public, was well received and attended.

Meeting March 21 in Quitman, Georgia, was the THOMAS-BROOKS COUNTY MEDICAL SOCIETY. Heading a program entitled, "Correlation of Pathological and Radiological Findings," were Dr. Robert Pendergrass, Radiologist, and Dr. Frederick Thompson, Pathologist, both of Americus.

William D. Logan, Jr., Department of Thoracic Surgery, Emory University, spoke to the WARE COUNTY MEDICAL SOCIETY at the February meeting held in Waycross. Dr. Logan's topic concerned the heart, and was followed by Dr. Roy Crispin, Chief Resident of Thoracic Surgery, Emory University, who spoke on highlights in the history of surgical treatment of coronary diseases.

PERSONALS

First District

JOHN L. ELLIOTT, Savannah, spoke to the Savannah Association of Life Underwriters at the Association's February meeting. Dr. Elliott's topic concerned socialized medicine and the proposals concerning it which were likely to be introduced in congress this year.

Gracewood State School and Hospital Superintendent, NORMAN BRUNDAGE PURSLEY, spoke to the February meeting of the Woman's Auxiliary of the Georgia County Medical Society. After showing a film detailing some of the programs and projects to help retarded children at Gracewood, Dr. Pursley answered questions from attending parents.

Four Savannah Urologists, C. L. PRINCE, PETER L. SCARDINO, IRVING VICTOR, and S. T. SU, have announced their association in a clinic at 2515 Habersham Street, where Dr. Prince and Dr. Scardino presently have their offices. Construction on the new offices, to be known as the Savannah Urological Clinic, was started in early February.

Second District

M. G. MIDDLETON and E. E. DAVIS, Thomasville, were among 14 physicians from Georgia and adjacent states attending a postgraduate psychiatric course the second week in February on the campus of the Medical College of Georgia, Augusta. The course highlighted physical, neurological, and emotional aspects of growth and development during infancy, childhood, and adolescence.

CHARLES H. WATT, JR., Thomasville surgeon, was elected Chief of the medical staff at Archbold Memorial Hospital at the regular monthly meeting. He succeeds WARREN TAYLOR.

Other new officers are FRANK LITTLE, Vice-Chief of Staff, who succeeds Dr. Watt in that post; E. E. DAVIS, Secretary, succeeding Dr. Little; and J. J. COLLINS, who was reelected Treasurer.

JULIAN NEEL was elected Chief of the Department of Surgery and M. G. MIDDLETON was named chief of the Department of Medicine in separate meetings of the two groups.

Third District

Speaker for the January meeting of the Fort Valley

Lions Club was CHARLES H. FIELDS, Macon. Dr. Fields gave a complete report on the King-Anderson bill and the Kerr-Mills bill.

Fourth District

No news submitted.

Fifth District

A panel discussion on Medicare was sponsored by the Atlanta Temple Couple's Club March 1 in the Temple's Friendship Hall. Speaking in favor of federal medical aid to the aged were WILLIAM WHITTING of London, England, and Emory University, and LOUIS NEWMARK, Executive Director of the Jewish Home for the Aged. Against Medicare on the panel were JAMES KAUFMANN and J. FRANK WALKER, Atlanta.

Attending the American Federation for Clinical Research and the Southern Society for Clinical Research meeting in New Orleans, January 24-26 were, J. WILLIS HURST, ELBERT TUTTLE, JOHN GALAMBOS, LEON GOLDBERG, JOHN R. K. PREEDY, ROBERT F. KIBLER, WILLIAM C. WATERS, III, JOE TURNER, GORDON CROWELL, JAMES ACKER, RICHARD FOSTER, JOEL STEINBERG, MARTA STEINBERG, and ERIN SACIT.

EDGAR BOLING, Atlanta, was one of the featured speakers at the recent Atlanta Graduate Medical Assembly held in Atlanta February 18-20. Dr. Boling spoke on cancer of the lower intestinal tract.

Three Atlanta doctors appeared on panel discussions during the section meeting of the American College of Surgeons held February 11-13 in Charlotte, N. C. EDGAR BOLING participated in a panel on "Colorectal Surgery;" JAMES ELLIOTT SCARBOROUGH, JR. was on a panel discussing, "Management of Malignant Breast Lesions—How Radical. Hormone and Adjunctive Therapy;" and OSLER A. ABBOTT contributed to a panel on, "Congenital Lesions in Pediatric Surgery."

JOEL P. SMITH presented a paper on "Alleviation of Post-Tonsillectomy Pain and Infection" at the Southern Section Meeting of the American Laryngological, Rhinological and Otological Society in New Orleans, January 18, 19. Also attending the meeting were: LESTER A. BROWN, JAMES T. KING, NATHAN I. GERSHON, WILLIAM R. FISHER, RUSSELL BURKE and CALHOUN McDOUGALL.

Six Atlanta doctors recently took part in a panel sponsored by the Delta and Allied Medical Careers Clubs of North Fulton High School, Atlanta. Answering questions on subjects ranging from teased hair to proper brushing of teeth were, CHENAULT HAILEY, ROBERT WELLS, WILLIAM SCHATTEN, ROBERT VAN DE WETERING, ROBERT BUNNEN, and ERNEST BEASLEY.

On February 16 SIDNEY OLANSKY was host to 253 doctors and their wives at a meeting of the Southeastern Dermatological Association. On February 17, thirty-three clinical presentations were made at Grady Clinic and microscopic slides were presented by MARY LOU APPLEWHITE.

THE ASSOCIATION / Continued

Sixth District

A panel discussion broadcast February 12 over radio station WMVG, Milledgeville, served to answer many questions concerning the Blood Pressure Survey now underway in Baldwin County. Participating in the panel were EDWIN W. ALLEN, JR., Milledgeville, and JOSEPH A. WILBER, Atlanta.

Seventh District

ROSS WHATLEY, Cartersville, has recently been nominated to serve as the 1963 President of the Cartersville Rotary Club.

LUKE GARRETT, Austell Mayor, discussed some of the medical causes of mental retardation on WSMA, Smyrna, in a recent radio broadcast sponsored by the Cobb Shop, Inc. of Smyrna.

CHARLES K. RICHARDS, Calhoun, began a three year residency in radiology February 1, in Atlanta. Dr. Richards has been associated with WILLIAM THOMPSON and BILL PURCELL, Calhoun.

Rome physicians, RALPH JOHNSON, JOHN McCALL, EMMETT BRANNON, JOHN TATE, RALPH McCORD, and JAMES HILL have announced the construction of new offices adjacent to McCall Hospital in Rome. The new building will be named McCall Clinic, Inc.

Eighth District

Speaking to classes of the Ware County Medical Assistants, Memorial Hospital, Waycross, on February 28, were ROBERT SMITH, speaking on the lymphatic system, and E. B. BROWN, speaking on gynecology. At an earlier meeting W. B. BATES and S. W. CLARK spoke on the nervous system and diseases of the eye, respectively.

CARTER SMITH, Atlanta, was the featured speaker at the Ben Hill County Heart Council's kick-off dinner held February 4, in Fitzgerald. Dr. Smith spoke on the recent advances made in the last 10-15 years in treating heart conditions.

EXECUTIVE COMMITTEE OF COUNCIL MEETING

THE REGULAR MONTHLY MEETING of the Medical Association of Georgia Executive Committee of Council was held February 17, 1963, at 10:00 A.M., at the MAG Headquarters Building, Atlanta.

President Goodwin called the meeting to order at 10:04 A.M.

The members of the Executive Committee present were: Thomas W. Goodwin, Augusta; George R. Dillinger, Thomasville; John T. Mauldin, Atlanta; J. G. McDaniel, Atlanta; Fred H. Simonton, Chickamauga; George H. Alexander, Forsyth; Lee H. Battle, Rome; and John S. Atwater, Atlanta. Guests present were: J. Frank Walker, Atlanta; Virgil Williams, Griffin; and Mr. Frank Drapalik, MAG Auditor. Staff members present were: Mr. Milton D. Krueger, Mr. James M. Moffett, Mr. James Baker, Miss Thelma Franklin and Mrs. Catherine Wooten.

Reading of Minutes

The minutes of the January 19, 1963, Executive Committee meeting were read by Mr. Krueger. An omission was called to

At the February 4 class meeting of the Ware County Medical Assistants Association, Waycross, ANSLEY SEAMAN spoke on, "Diseases of the G.I. Tract."

JAMES T. NUNNALLY, III, Hazelhurst, recently announced the closing of his medical practice.

Ninth District

WILLIAM G. HAMM, Atlanta, spoke in January to the Gainesville Rotary Club. His talk concerned the relationship of psychiatry to plastic surgery. Dr. Hamm has for many years been consultant in plastic surgery to the Atlanta Federal Penitentiary.

Tenth District

PRESTON ELLINGTON and JOSEPH P. BAILEY, Savannah, spoke to the Savannah YWCA at its February meeting. Dr. Ellington's topic concerned, "Ladies, You Are Too Fat," and Dr. Bailey's talk was entitled, "What Price Fat?"

ALOYSIUS I. MILLER, Atlanta, took part in a panel discussion held February 17 at the Georgia Center for Continuing Education in Athens. The discussion, entitled, "Your Child's Development," was sponsored by the St. Joseph's Parents' Club in Cooperation with the Council of Women, Athens.

H. J. FORD, Athens, recently joined the medical staff of the University of Georgia's Gilbert Memorial Infirmary.

Eight Northeast Georgia physicians recently took part in a series of four heart programs televised on WGTV, Athens. The programs were sponsored by the Northeast Georgia Heart Council and were presented as follows: "Congestive Heart Failure," Moderator: GOODLOE Y. ERWIN, Athens, and Speaker, WILLIAM B. FACKLER, JR., LaGrange. "Stroke Rehabilitation," Moderator: JOE GRIFFITH, Commerce, and Speaker, B. SHANNON GALLAHER, Augusta. "Rheumatic Fever," Moderator: KENDRICK LEWIS, Madison, and Speaker, SAM HAY, Toccoa. "Services and Facilities Available to Heart Patients," Moderator: JOHN STEGEMAN, Athens, and Speaker, J. GORDON BARROW, Atlanta.

the attention of Mr. Krueger in the "AMA Medicolegal Symposium, March 8-9, 1963, Miami Beach" paragraph. Dr. Charles S. Jones' expenses were to be paid by MAG but no mention was made as to where the funds would be taken for this purpose. Therefore, on motion duly made and seconded it was voted to add to this paragraph "The funds for Dr. Jones' expenses in connection with the meeting should be charged to the Contingent Fund." After this correction the minutes were approved as read.

MAG Sub-Committee Appointments

The Executive Committee appointed the following members on the below listed Sub-Committees:

Mental Health Sub-Committee: James N. Brawner, Atlanta, Chairman, with J. R. S. Mays, Macon, to attend the March 1-2, 1963, Ninth Annual Conference of Mental Health Representatives of State Medical Associations, Drake Hotel, Chicago.

Disaster Medical Care Sub-Committee: James W. Harkess, Augusta; and Dr. Charles B. Brown, Atlanta, State Department of Health, as an ex-officio member.

Rural Health Sub-Committee: J. S. Garner, Rome, and R. D. Walter, Calhoun.

Advisory Committee, Georgia Health Education Program: Allen McDonough, Atlanta.

Workmen's Compensation

Dr. McDaniel reviewed the proposed revised fee schedule for Workmen's Compensation which had been submitted by the Workmen's Compensation Board, and Dr. Mauldin gave background information. After discussion it was decided to write T. A. Peterson, Savannah, Chairman of the MAG Occupational Health Board, that the Executive Committee has given tentative approval of the schedule as submitted, with the recommendation that it be referred to his Board for recommendations to Council.

Certificates of Appreciation

Mr. Krueger asked the Executive Committee to consider designees for Certificates of Appreciation. The President of the Association; the Secretary (if his term of office expires); Chairman of Council; First Vice President; and consideration of Thomas A. Hendricks and Joseph Stetler, of the American Medical Association, were considered.

MAG Awards

Mr. Krueger explained the procedure for choosing the Hardman Award and the Distinguished Service Award recipient.

MAG Liaison

As a follow up from the Special Projects Meeting held in January, Mr. Krueger read a draft of a proposed plan for additional delegates elected and appointed to the Medical Association of Georgia House of Delegates from various specialty groups, medical schools, public health services (state and federal), etc. The Executive Committee approved this plan, and on motion duly made and seconded it was voted that this proposed plan be referred to Council with the Executive Committee recommendation for approval.

Auditor's and Treasurer's Report

Mr. Frank Drapalik, MAG Auditor, reviewed the Auditor's Report. Dr. Atwater then gave the Treasurer's Report. Executive Committee voted approval of these two reports as presented. Dr. Atwater asked for a decision on the purchase of the coke machine. It was recommended that this purchase be charged to meetings.

Headquarters Office Functions and Policies

Dr. Mauldin discussed the purchase of a folding and inserting machine for Headquarters Office. Mr. Krueger gave several prices on folding machines and the combination folding and inserting machine. On motion (Simonton-McDaniel) it was voted to purchase the Pitney-Bowes folding and inserting machine on a cash sale, with funds to be taken from the Contingent Fund.

County Medical Society Professional Conduct Problem

Dr. Virgil Williams, 4th District Councilor, reported on a county society professional conduct problem which he had been asked to investigate. It was recommended that this information be given to Dr. Goodwin for discussion with Dr. Savage of the State Board of Medical Examiners.

S.B. 289—Mr. Moffett stated that this Bill provides for a Board of Medical Examiners consisting of one member from each Congressional District. The District Medical Societies would furnish the Governor a list of two names and he would choose one. The present members would serve out terms on the Board. After discussion it was suggested that Mr. Cecil Clifton, Joint Secretary, State Board of Medical Examiners, be contacted and told that MAG recommends that the above mentioned Board be appointed similarly to the State Board of Health, as stated in the Medical Practice Act.

MAG Staff

The Executive Committee discussed the promotion of Mrs. Catherine Wooten to Assistant Executive Secretary, and on motion duly made and seconded it was voted to recommend to Council Mrs. Wooten's appointment to Assistant Executive Secretary, and to further evaluate the need for an additional employee in June.

American Cancer Society Exhibit

Mr. Krueger read a letter from the Coca-Cola Company

regarding the Medical Association of Georgia's endorsing of an exhibit used by the American Cancer Association at the Seattle Worlds Fair. This exhibit will be on display at the Georgia Power Company Building, March 1-16. The Fulton County Medical Society has granted permission to be listed as co-sponsor, and on motion duly made and seconded permission was granted to allow MAG to co-sponsor the exhibit also.

Georgia State League for Nursing Agency Membership

After discussion on motion duly made and seconded it was voted that MAG should not become a member of the Georgia State League for Nursing.

Tenth Street Business Association

After discussion as to the merits of membership in the Tenth Street Business Association, it was voted to continue membership.

Legislative Committee Report

Dr. Walker and Mr. Moffett reported on national legislation. Dr. Mauldin discussed the means for increasing the Kerr-Mills program in Georgia by considering an MAA program in the state. Executive Committee gave authority to Dr. Mauldin, as Medical Director of the MAA program in Georgia, to work out a program on the implementation of the MAA program. It was suggested that the Executive Committee members begin a "spot check" in their areas; to discuss this at the County Society Officers Conference March 2-3, 1963; and to place this item on this March Council meeting agenda for discussion of the possibility of holding a statewide meeting.

Dr. Walker suggested an organized Speakers Bureau as more and more requests for trained speakers are coming in.

Executive Committee approved the program as presented with the admonition to keep expenses to a minimum. President Goodwin suggested that this program be presented at the County Society Officers Conference and at the March Council Meeting.

Mr. Moffett read a list of the bills pending before the State Legislature in which the Medical Association of Georgia is interested and the Executive Committee took the following action:

H.B. 142 (Day Centers for the Mentally Retarded): No position.

H.B. 163 (Public Health Laws Recoding Bill): Support.

H.B. 163 (Cost of Care Bill): Suggested changing wording of "medical care" to "professional care" and support.

H.B. 291 (Veterans Service Board): No stand.

H.B. 289 (Composition of Board of Medical Examiners): Support.

Senate Bill (Seat Belts for Automobiles): Support.

S.B. 35 (Podiatry Bill): Oppose. Hearing is scheduled for February 18. Representatives from MAG and Blue Shield Plans in Georgia will be present.

Unfinished Business

(a) Guest Speaker for Annual Session—After discussion it was decided to ask President Goodwin to inquire if James W. Harkess, Augusta, could be the guest speaker.

New Business

(a) Walton County Medical Society Resolution on Podiatry: Executive Committee voted to refer this to Council.

(b) Student Study on the Mobility of Physicians: A student at the University of Georgia desires to make a study on the mobility of physicians in Georgia, and asked the Medical Association of Georgia's approval in writing to be mailed with his questionnaire. It was suggested that this student (Mr. Louie A. Brown) be invited to the March Council meeting in Athens to present his request.

(c) Jack Hughston, Columbus, Request for Payment: Dr. Hughston's itemized statement of his expenses in connection with attendance at the AMA Sports Conference in 1962 was read. He has requested payment of these expenses, and after discussion, it was voted to pay the expenses from the Contingent Fund.

(d) Dr. Battle discussed the possible closing of Battey General Hospital in Rome. Received for information.

(e) At Dr. Mauldin's suggestion it was voted to transfer \$9,000.00 from the Contingent Fund to a savings account, and to ear-mark this money for a specific purpose.

(f) Dr. Mauldin asked MAG help in defraying expenses for the printing of a new manual for the Georgia Hospital-Medical Council. It was suggested that it be recommended to Council that \$500.00 be given by MAG. Dr. Mauldin also stated that an accrediting program for nursing homes by the Georgia Hospital-Medical Council was in the process. It was suggested that it be recommended to Council that MAG approve this program and help defray any expense in connection with this program. On motion duly made and seconded it was voted to approve Dr. Mauldin's requests as stated above.

(g) Date and site of March Executive Committee Meeting: March 23, 1963, 11:00 A.M., Athens.

There being no further business the meeting was adjourned at 4:45 P.M.

SUB-COMMITTEE ON BLOOD BANKS

THE MEETING of the MAG Sub-Committee on Blood Banks was called to order by Chairman Jack C. Norris at 12:30 P.M., February 20, 1963, in Room 1014 at the Biltmore Hotel, Atlanta, Georgia.

Sub-Committee members present included Chairman Norris, Atlanta; Dr. Walter Sheppard, Medical College of Georgia, Augusta; and Dr. Irving Greenberg, Atlanta. Also present at the meeting were Dr. Joseph W. Iseman, Atlanta, representing the American Red Cross; and Dr. S. C. Rutland, representing the Georgia Department of Public Health. Mr. James M. Moffett, Assistant Executive Secretary, MAG, attended as staff for the Sub-Committee.

Minimum Standards for Blood Banks

Following the luncheon, Chairman Norris made a few introductory remarks in which he explained that one of the important reasons for this meeting was to consider progress being made on the establishment of minimum standards for blood banks in Georgia. He pointed out that this project had been assigned to the Blood Banks Sub-Committee by the Speaker of the MAG House of Delegates pursuant to an action taken by the House.

Dr. Sheppard discussed this undertaking with the Sub-Committee pointing out several legal aspects of blood transfusion service from the donor to the recipient of the blood. General discussion followed in which many of the pertinent areas to be covered by the minimum standards were explored. Dr. Sheppard was urged to complete his work on these standards as soon as possible. In the interim, the Chairman requested Dr. Iseman to draft a set of working standards that may be used until the official MAG standards are drawn, approved and distributed.

Blood Banks Investigation Unit

Following general discussion of the need for a separate unit of the Georgia Department of Public Health, charged with the responsibility for investigating hospital blood banks, the following resolution (Greenberg-Sheppard) was adopted:

"BE IT RESOLVED by the Sub-Committee on Blood Banks, Medical Association of Georgia, Jack C. Norris, Chairman, and the members: That the Health Officer, Department of Health, State of Georgia, be requested to proceed to establish in the department, a division entitled: 'State Health Department of Blood Banking,' this unit to be under the direction of either a Pathologist, Clinical Pathologist, Hematologist or a licensed doctor who is recognized as a person capable of placing the division into proper perspective and development; whose other duties as the Director, shall be to investigate, inspect, and cooperate with State located hospitals or clinics whose staff administers blood to patients, or who may desire to have them do so at a future date; to certify same, and to draw plans for the proper storage of blood and its therapeutic constituents which may be needed in emergency; to further determine the operative fitness of hospitals having blood banks, including technical efficiency, to the extent that the public and the patients shall be protected; to cooperate with the American Red Cross and The American Association of Blood Banks; that legal steps to the establishment of this department be duly presented to the next available Legislature, in order that lawful status may be enacted to execute and promote the intent and purpose of this Resolution."

Enlargement of Sub-Committee

Dr. Norris advanced the idea that this Sub-Committee might be more perfectly constituted by the addition of two new members giving the Sub-Committee a membership of five rather than its present three.

Following discussion of this idea, the following resolution (Greenberg-Sheppard) was adopted:

"BE IT RESOLVED that the Executive Committee of MAG be requested to enlarge the membership of the Sub-Committee on Blood Banks by the addition of Dr. Joseph Iseman (American Red Cross) as an ex-officio member, and Dr. S. C. Rutland (Georgia Department of Public Health) as a member."

Hospital Memorandum

Chairman Norris requested and received, concurrence by the other members of the Sub-Committee to send to every hospital in Georgia a copy of a memorandum on the subject of "Hospital Transfusion Committees." The memorandum reads as follows: "Memorandum to all Hospitals in Georgia: The Sub-Committee on Blood Banks, Medical Association of Georgia, wishes to recommend to and urge all hospitals in the State who receive and administer BLOOD TRANSFUSIONS to appoint a 'TRANSFUSION COMMITTEE' on their Staffs composed of three persons, preferably a surgeon, an internist, and a member of the Laboratory. Essentially this Committee would cooperate with the blood bank in every respect in order to enhance its safety and performance, and particularly to investigate every REACTION occurring after blood has been given to a patient, reporting same to the Sub-Committee, or the American Red Cross Blood Bank, Atlanta, Georgia.

There being no further business before the Sub-Committee, Chairman Norris adjourned the meeting at 3:20 P.M.

MEDICAL EDUCATION BOARD MEETING

THE MEETING of the Medical Association of Georgia Medical Education Board was called to order by Chairman T. A. Sappington at 2:15 P.M. on February 24, 1963, at the MAG Headquarters Office Building, Atlanta, Georgia.

Members of the Board present included: T. A. Sappington, Thomaston, Chairman; Walter Bloom, Marietta; Braswell Collins, Macon; and W. H. M. Weaver, Macon. Also present was Mr. Milton Krueger of the Headquarters Office Staff.

Dr. Sappington reported on the Medical School Sub-Committee activity, and he stated that because of other matters and for a re-evaluation, the annual course "Art of the Practice of Medicine" had not been scheduled for January through March of 1963. He discussed the fine reception for this course in the past five years at the Medical College of Georgia and the difficulty in scheduling such a course at Emory University School of Medicine. He assured the Board that the course would be scheduled for 1964.

Dr. Walter Bloom reported on the activity of the Medical Education Sub-Committee, and reported on attending the AMA Congress on Medical Education and Licensure held in Chicago in February.

Dr. Bloom outlined a program of medical recruitment, describing the Oklahoma brochure, the AMA Medical Career Kit, the AMA movie, "I Am A Doctor," and the AAGP Project More. Dr. Bloom cited these tools for use in a medical recruitment project, and it was recommended that Dr. Bloom rough draft a plan and a brochure for MD recruitment in Georgia and include this plan in his report to the MAG House of Delegates which will also be incorporated in Medical Education Board Chairman T. A. Sappington's report.

Dr. Bloom then also outlined a proposed Georgia Conference on medical education to be held in the State of Georgia on a statewide basis. The Board recommended that Dr. Bloom propose a plan, program and other details of such a meeting and work with Board Chairman Sappington in this connection so that the meeting may be convened late in 1963.

Dr. Bloom also discussed for some future date the Association co-sponsorship with community hospitals or medical societies of scientific programs. It was the recommendation of the Board that this project be held in abeyance at this time but be given full consideration in the near future.

Dr. Braswell Collins reported on activity of the AMA-ERF Sub-Committee which replaces the AMEF Committee.

After due discussion of medical education matters in general the meeting was adjourned at 3:45 P.M.

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Contents

Scientific Articles

- THROMBOSIS OF ANEURYSMS OF THE ABDOMINAL AORTA
Garland D. Perdue, Jr., M.D. 201
- A SIMPLIFIED TECHNIQUE FOR CANCER INFUSION
CHEMOTHERAPY
B. A. Addison, M.D., and E. R. Jennings, M.D. 203
- SURGICAL CORRECTION OF CHRONIC STASIS ULCER OF
LONG DURATION, A CASE REPORT
P. C. Shea, Jr., M.D. 205
- OBSTRUCTION OF THE MALE URETHRAL MEATUS
Donald J. McKenzie, M.D., and Peter L. Scardino, M.D. 208
- EVALUATION OF METHYLCLOTHIAZIDE THERAPY FOR
ANGINA PECTORIS
Nanette Kass Wenger, M.D., Austin Flint, Senior Medical Student,
and Robert P. Wight, Jr., Senior Medical Student 210

Special Article

- 1963 REVISED WORKMAN'S COMPENSATION
AVERAGE SCHEDULE OF FEES 212

Editorials

- TYPHOID FEVER 215
- "SEE YOU IN ATLANTIC CITY" 216
- THE IDENTIFICATION OF "PSEUDONEUROTIC" OR
"BORDERLINE" SCHIZOPHRENIC PATIENTS IN
GENERAL MEDICAL PRACTICE 217

Features

- How Well Are We Telling
Our Story? 214
- Cancer Page 221
- Heart Page 223
- Legal Page 225
- Mental Health Page 227
- Current Clinical Concepts 229
- Personals 231
- Medical Education Board
Meeting, February 24 232
- MAG Rural Health Committee
Meeting, March 17 232
- Executive Committee of
Council Meeting, March 23 232
- MAG Council Meeting,
March 23 233
- Advertising Index 38A

The Association

- Deaths 230
- Societies 230

Cover

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THROMBOSIS OF ANEURYSMS OF THE ABDOMINAL AORTA

Garland D. Perdue, Jr., M.D., *Atlanta*

- ***Even small asymptomatic aneurysms may be a source of major complications.***

PERMANENT DILATATION OF AN ARTERY results in slowing of blood flow and increased lateral pressure which causes further enlargement of the vessel. Relative or actual narrowing of the outlet from such a vessel results in turbulence and eddy currents which predispose to thrombus formation. Thus, a mural thrombus is an almost universal occurrence in arterial aneurysm, and since clot formation is a continuing process, the thrombus tends to be deposited in layers on the arterial wall. Though this serves to partially strengthen the wall of the aneurysm, it also may be the cause of disastrous complications.

Frequent Source

Such mural thrombi are a frequent source of distal emboli, particularly in femoral and popliteal aneurysms. The aortic aneurysm also may be the source of peripheral emboli. Complete thrombosis is a common occurrence in femoral and popliteal aneurysms, and in the latter is often the cause of the first symptoms. The importance of these complications is illustrated by the report of Gifford, Hines, and Janes,³ in which 20 of 100 patients with popliteal aneurysms required amputation at the time of, or shortly after, the first examination, because of gangrene due to thrombosis or embolization. Occurrence of such complications from aortic aneurysms has

been mentioned by several authors, and Janette and Roberts⁴ described one case of complete thrombosis of an aortic aneurysm in detail.

The natural tendency of aortic aneurysms to expand and rupture in a large percentage of cases is sufficient indication of the lethal nature of these lesions. In spite of this there is a wide reluctance to recommend surgical excision of a small aneurysm unless progressive expansion and increase of symptoms indicate imminent rupture. The following case reports illustrate that even the small, otherwise asymptomatic aneurysm may be a source of major complications.

A 52-year-old man was first admitted to Emory University Hospital in October 1952, for evaluation of a small, asymptomatic aneurysm of the abdominal aorta. The patient had previously had amputation of his right leg following trauma. Distal pulses in the left leg were normal, and blood pressure was 150 over 100. No surgery was recommended at this time.

Arterial Insufficiency

The patient was next seen on 1-11-56 for acute arterial insufficiency to the left leg and to the right thigh of approximately 12 hours duration. The left leg was totally ischemic from the mid-thigh down, with purplish discoloration and coolness extending to the level of the iliac crest. Similarly, the right thigh was discolored up to the level of the iliac crest. No pulses were palpable below the upper ab-

From the Joseph B. Whitehead Department of Surgery, Emory University School of Medicine, Atlanta, Georgia.

dominal aorta. Laparotomy revealed a five cm. arteriosclerotic aneurysm of the terminal aorta, the lumen of which was completely occluded by fresh thrombus which extended up to the level of the renal arteries. There was also extensive distal propagation of the clot, but thromboendarterectomy to the femoral level resulted in backflow of blood from this vessel. The aneurysm was resected, and aortic continuity restored with a bifurcation homograft.

In spite of the restoration of pulses to the left leg, its color failed to improve, and it remained anesthetic and paralyzed. Within 24 hours, the pulsations below the knee had ceased, though a femoral pulse remained present. It was thought that the ischemic changes of the foot and lower leg were irreversible, and a mid-thigh amputation was done.

Patient Number Two

A 59-year-old man was admitted to Emory University Hospital on 11-8-58, because of severe lower abdominal and back pain with numbness and inability to move both lower extremities of about two hours duration. During the preceding month, the patient had had several similar transient episodes. On examination, both lower extremities were ischemic with mottled discoloration extending to the iliac crests. No pulses were present in the lower extremities. At laparotomy, a five cm. arteriosclerotic aneurysm was found in the terminal aorta just below the renal arteries. The aneurysm was totally occluded by fresh thrombus, as was the left renal artery. The kidney was infarcted. Removal of the aneurysm and the left kidney was done with restoration of aortic continuity with a Teflon prosthesis. Revascularization was accomplished, but the patient sustained a massive myocardial infarction in the immediate postoperative period, and died 24 hours later. The cause of death was confirmed by postmortem examination.

Patient Number Three

A 57-year-old man was admitted to Emory University Hospital on 4-8-62, approximately three hours after onset of progressively severe pain, anesthesia, and paralysis of both lower extremities. His previous health had been good, and the patient had not seen a physician for many years prior to onset of these symptoms.

On examination, he was found to have severe ischemia of both lower extremities with mottled discoloration extending to the iliac crest. All pulses of the lower extremities were absent. Operation revealed a five cm. aneurysm of the terminal aorta

which was filled with fresh clot. The clot extended into both iliac arteries, and severe atheromatous disease was noted in both of these arteries. The aneurysm was removed and thromboendarterectomy was performed on both iliac arteries, with arterial continuity being re-established with a Teflon prosthesis. Revascularization was satisfactorily accomplished, but 12 hours after operation the patient sustained a massive inferior myocardial infarction and died a few hours later. The cause of death was confirmed by postmortem examination.

Aneurysm Small

In each of the three patients described, the aneurysm was comparatively small and had been asymptomatic prior to onset of the catastrophic complication. In patient Number Three, there was severe occlusive disease in the iliac vessels which probably predisposed the patient to thrombus formation in the aneurysm. The other two patients had no significant occlusive disease, but in one, dissection beneath the clot was demonstrated and probably resulted in the acute thrombosis. A shift in the position of the mural thrombus was also suspected as the cause of the acute occlusion in the case reported by Janetta and Roberts.

Elective removal of aneurysms in patients who are reasonable operative risks is recommended by most vascular surgeons. The incidence of enlargement and rupture as indicated in the five-year survival studies of Estes,² Wright,⁵ and Crane,¹ is sufficient to justify this opinion. The occurrence of thrombotic complications lends further support to this recommendation.

Summary

Three patients with acute complete thrombosis of aneurysms of the terminal aorta are reported. This disastrous complication occurred in small, previously asymptomatic, lesions.

The occasional occurrence of thrombotic complications is further indication for the elective removal of aneurysms of the abdominal aorta.

Emory University School of Medicine

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A SIMPLIFIED TECHNIQUE FOR CANCER INFUSION CHEMOTHERAPY

B. A. Addison, M.D., and E. R. Jennings, M.D., *Brunswick*

SLOW CONTINUOUS INTRAARTERIAL drug infusion into regions involved with carcinoma is showing some promise in malignant tumor control. Duff,¹ and others have elicited good responses with infusion chemotherapy of some carcinomas after conventional methods of treatment have failed.

New Method

These continuous infusion techniques have required specialized pumps and devices to deliver the therapeutic drug at arterial pressures over long periods of time. A new method for accomplishing successful infusion with inexpensive, simple, and reliable equipment has been devised which has proved to be of considerable benefit, and has replaced conventional equipment.

Procedure

A small catheter is placed in the artery supplying the region of the carcinoma. The distribution of the drug is checked by the injection of fluorescein through the catheter. The area receiving the drug will then fluoresce under ultraviolet light and establish the distribution of the infusion. The appropriate drugs are then infused through the artery at an established rate. This is accomplished by a vinyl plastic transfusion bag which is made with two separate compartments. One compartment accepts the fluid

to be infused. The second compartment accepts the air or oxygen which puts pressure on the dividing diaphragm and forces the fluid from its compartment. A positive pressure from pump or oxygen source is regulated by a small spring valve monitored by a blood pressure manometer. The pressure and flow rate can be easily regulated by means of the valve (Figures 1, 2, 3). Early experiences with this technique reveal it to be a simple method for sup-

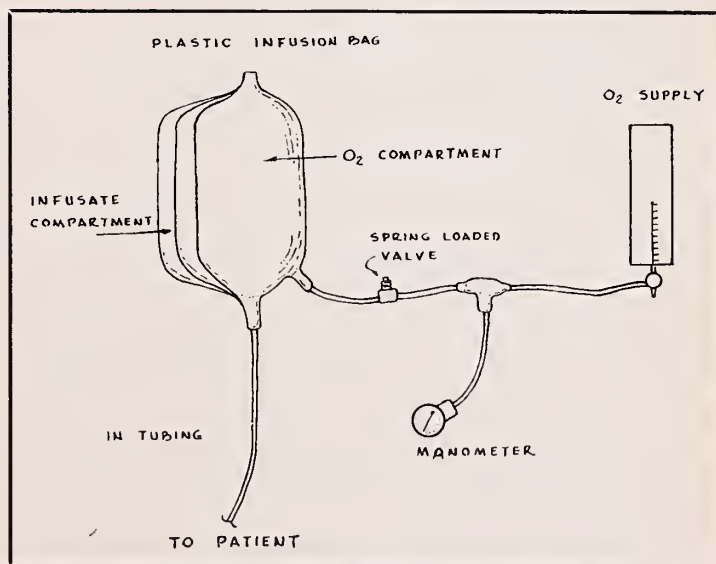


Figure 1
Diagram of the basic essentials for pressure infusion.

plying the infusate at arterial pressures without complicated and expensive equipment.

2432 Parkwood Drive

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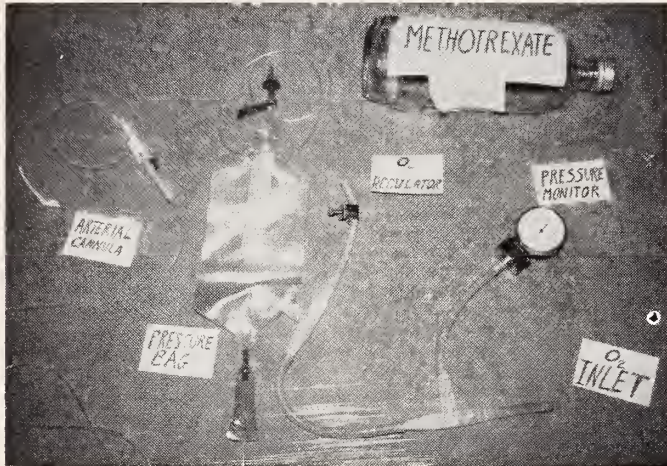


Figure 2
Photograph of complete assembly.

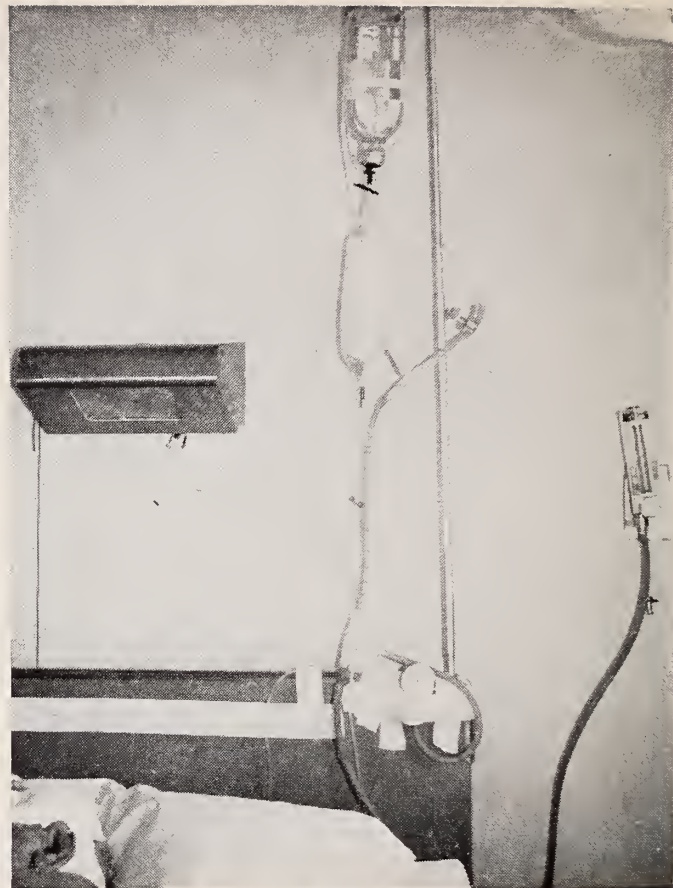


Figure 3
Infusion assembly on a patient receiving therapy.

WOMAN'S AUXILIARY 40TH CONVENTION COINCIDES WITH AMA ANNUAL MEETING

How physicians' wives can best serve their local communities and how to tell the public and profession about these services projects will be featured presentations of the 40th annual convention of the Woman's Auxiliary to the American Medical Association.

Reports emphasizing the Auxiliary's community service activities in the areas of civil defense, health career recruitment, mental health, international health, safety and rural health will be given to nearly 2,000 physicians' wives attending the convention June 16-20 in Atlantic City. Auxiliary headquarters will be the Haddon Hall Hotel.

Formal opening of the Auxiliary's house of delegates will be Monday morning, June 17.

A special program for all physicians' wives featuring practical suggestions for carrying out community service projects and telling the story will be given Tuesday morning.

The annual tea honoring the president, Mrs. William Thuss of Birmingham, Ala., and the president-elect, Mrs. C. Rodney Stoltz of Watertown, S.D., will be held Sunday afternoon.

National Auxiliary past presidents will be honored at Tuesday's luncheon. Dr. George M. Fister, AMA president, Ogden, Utah, will be guest speaker. The Auxili-

ary's annual contribution to the AMA Education and Research Foundation will be announced at that time. Last year's check was \$244,172.

Mrs. Stoltz will be installed as Auxiliary president at the concluding business session Wednesday morning. Election and installation of other national officers will also be held that day with formal adjournment scheduled for noon.

A post convention conference and planning session for 1963-64 for all Auxiliary officers and members will be held Thursday morning. Dr. Ernest B. Howard, AMA assistant executive vice president, will discuss principal actions of the AMA house of Delegates.

A full program for teen-aged members of AMA families will be arranged throughout the week.

All members, their guests and guests of physicians attending the AMA annual meeting may participate in the social functions and general sessions of the Auxiliary.

Local arrangements are under the direction of Mrs. David B. Allman, Atlantic City, chairman. Vice chairmen include: Mrs. Edward H. Dyer, Mrs. Charles Hyman and Mrs. Harry Subin, Ventnor; N.J., Mrs. William E. Dodd, Beach Haven, N.J., and Mrs. Samuel L. Winn, Margate City, N.J.

A CASE REPORT

SURGICAL CORRECTION OF CHRONIC STASIS ULCER OF LONG DURATION

P. C. Shea, Jr., M.D., *Atlanta*

■ *Chronicity is not a contraindication to surgical correction of venous stasis ulcers.*

THE APPROACH TO THE PROBLEM of stasis ulcers must be engendered with some degree of optimism. Well-established methods and techniques are utilized, frequently employing a variety of surgical procedures. Admittedly, care may be tedious and lengthy, but favorable results can be obtained and are most gratifying. The following exemplifies just such a situation.

Case Report

E. H., Hosp. No. 4928A, a 51-year-old white male was referred with a chief complaint of an ulcer of 16 years duration on the left leg. Subjectively, however, it was determined that his chief desire for consultation was stimulated by (1) more recent persistent and increasingly aggravated pain, as well as, by (2) the offer of left leg amputation for relief.

The past history is important in that during 1944 and 1945 he experienced upwards of twelve months hospitalization elsewhere for correction of a post-phlebotic syndrome. The procedures performed included,

1. Bilateral high ligation, internal saphenous veins
2. Lumbar sympathectomy
3. Transabdominal ganglionectomy
4. Skin grafts—15 to 20
5. Below knee amputation, right

In spite of the above efforts, the ulcer on the left leg had existed for 16 years. Due to continuous discomfort, and dissatisfaction, over this period of time the

patient had become addicted to alcohol in a moderate degree.

Physical Examination

Physical examination revealed a well-developed, slightly obese male, weighing 188 lbs. with a normal temperature, pulse rate of 92, respiratory rate 16, and blood pressure was 150/100 in the right arm, and 120/80 in the left. General physical examination was not remarkable, except for the following features: The chest was increased in its A-P diameter and exhibited a moderate degree of kyphoscoliosis. Obstruction to the left axillary artery existed, but there was no loss of function in this extremity. There were marked varicosities with evident insufficiency in both lower extremities. There was marked tortuosity to the internal saphenous system on the left with many incompetent perforating veins, as well as collateral, present. The right leg had been amputated below the knee and a properly fitting prosthesis was utilized (Figure 1). On the medial aspect of the lower third of the left leg was a markedly indurated leg ulcer which had an overhanging edge (Figure 2). The ulcer measured five x four inches, and in its greatest depth $\frac{3}{4}$ of an inch. Its base was extremely firm, granular and moist, as well as being secondarily infected. At the center, the ulcer base appeared to be contiguous with bone or periosteum (tibia). The depth of the ulcer was not uniform. The arteries were normal. In addition, there was

marked brawny induration with acneiform pitting of all the skin of the leg from the ankle to the upper third. The achilles tendon was shortened due to inflammatory involvement by the ulcer directly overlying the medial aspect of this tendon. Marked pain was exhibited with extension of the gastrocnemius muscle.

Laboratory studies revealed a normal urine and hematogram. An electrocardiogram was normal. A chest X-ray demonstrated pulmonary emphysema with minimal fibrosis, and an old deformity of the left eighth, ninth and tenth ribs, as well as calcification and tortuosity of the thoracic aorta. X-ray of the left leg revealed generalized osteoporosis. Multiple small excisional biopsies revealed changes consistent with chronic stasis ulcer.

Hospital Course

The patient was admitted to St. Joseph's Infirmary on December 6, 1961, for evaluation and preparation for surgery. The above described laboratory procedures were obtained and he was seen in consultation by F. W. Fitzhugh, Jr., M.D., regarding his



Figure 2
Left leg ulcer; 16 years duration.



Figure 1
Right leg below knee amputation; for venous disease.

arterial hypertension, axillary artery obstruction, and cardiopulmonary reserve. During the first six days of his hospital admission, bed rest with elevation of the extremity was instituted, and oral diuretics were administered for maximum reduction of edema. In further preparation for surgery, the extremity was scrubbed three times daily with pHisoHex. Moist saline compresses were used on the ulcer with frequent changes of these dressings. On one occasion, the entire extremity was wrapped firmly from the base of the toes to the mid-thigh with an Ace bandage, and the patient walked steadily for one-half hour, without evidence of distress, to determine that his deep system was competent.

December 12, 1961: Radical excision of all incompetent varicosities; ligation of all incompetent perforating and collateral veins. Wide excision ulcer and ulcer bed.

December 20, 1961: Split thickness skin graft—ulcer defect.

January 5, 1962: Partial debridement necrotic area achilles tendon and skin graft of this area.

February 10, 1962: Excision of great toenail and subungual exostoses, left. (Incidental procedure)

February 18, 1962: Discharged.



Figure 3

Well-healed skin growth — areas of leg ulcer, left; six months postoperative.

Pathology

Varicose veins with phleboscrosis. Chronic thrombophlebitis and recanalized thrombosis. Chronic varicose ulcer with extensive dermal scarring and inflammation.

At the time of discharge, the skin graft was well healed and the patient was completely ambulatory. A foam rubber pad was used for pressure in the surface defect left by excision of the ulcer. A superimposed Ace bandage was applied from the base of the toes to anterior tibial tubercle. This dressing was utilized only in the waking state. Since then, the patient has been seen in follow-up on several occasions. He was returned again to full employment one month after discharge from the hospital and has not lost any time at work since. The operative area has remained healed (Figure 3). The patient is completely satisfied with his results.

Summary

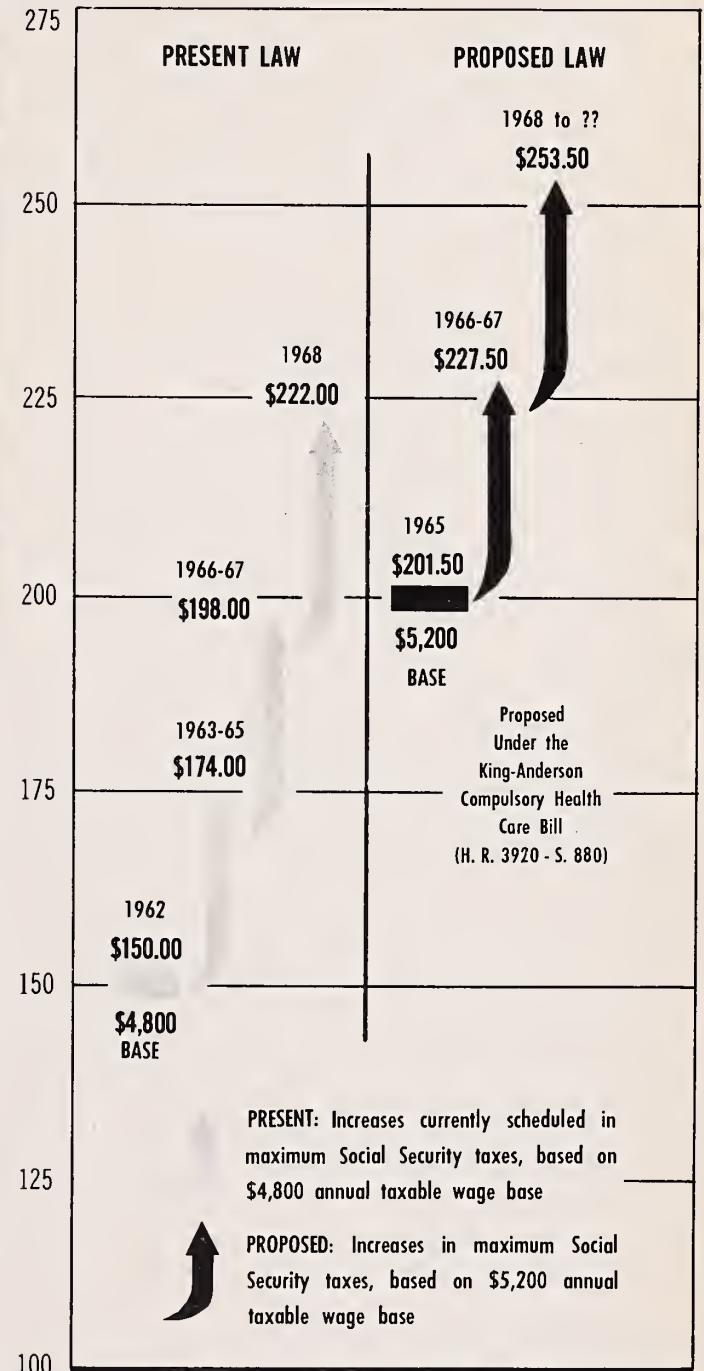
The above case report is presented to exemplify that chronic venous disease, complicated by ulcer, even of several years duration, can be corrected by standard surgical procedures. Close attention should be paid to eradication of venous defects.

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SOCIAL SECURITY:

Maximum Taxes Paid and Payable by each Employer and Employee under Present and Proposed Laws

Dollars



CHAMBER OF COMMERCE OF THE UNITED STATES

Social Security Taxes and the Self-Employed

Under present Social Security law and under the proposed King-Anderson bill, here's how maximum taxes shape up for self-employed business and professional men:

Present (\$4,800 base)—1963-65—\$259.20; 1966-67—\$297.60; 1968—\$331.20.

Proposed (\$5,200 base)—1965—\$301.60; 1966-67—\$343.20; 1968—\$379.60.

OBSTRUCTION OF THE MALE URETHRAL MEATUS

Donald J. McKenzie, M.D., and Peter L. Scardino, M.D., *Savannah*

- ***Because of its location, urethral meatal stenosis potentially affects the entire male urinary system.***

OBSTRUCTION OF THE URETHRAL MEATUS may result in proximal urethral dilatation, increase in bladder size, residual urine, uretero-vesical reflux and hydronephrosis with renal failure.^{1,2} Terminal pyelonephritis associated with an obstructed urethral meatus is not uncommon.³

Early Diagnosis

The diagnosis of urethral meatal stenosis must be made early if the sequelae of obstruction is to be prevented. An astute pediatrician or general practitioner may be the first physician to examine the male infant who may have been circumcised but whose urethral meatus was either not evaluated or whose caliber was thought to be adequate. If carefully inspected many male children will be found to have an inadequate urethral meatus due to a partially occluding thin membrane which has persisted since birth. The general practitioner or internist may encounter urethral stenosis secondary to the effects of the poorly understood collagen diseases one of which affects the glans penis as balanitis xerotica obliterans. This meatal occlusive disease is not an infrequent finding in the middle aged male. Prostatic surgical procedures especially transurethral electroprostatic resection has as one of its minor complications fibrosis of the urethral meatus. The signs and symptoms of this complication are essentially those of prostatic ob-

struction. The patient and his referring physician may experience disappointment following prostatic surgery without realizing that recurring symptoms are often secondary to the late (2-8 weeks) development of meatal stenosis or urethral strictures rather than the recurrence of prostatic disease or inadequate prostatic surgery.

Case Reports

Case Number One: A 12-year-old white male, whose history was that of urinary frequency every ten to 15 minutes, was referred by his pediatrician. A pinpoint urethral meatus was noted and corrected by simple meatotomy. An immediate postoperative result was demonstrated by the adequate urinary stream.

Congenital meatal urethral stenosis is a common form of obstructive male uropathy. Ulceration of the urethral meatus may be the first sign of obstruction as evidenced by spotting of blood on the child's underwear.⁴ Straining or voiding, comparable to straining at stool has been observed. Recurrent urinary tract infection is often associated with the obstruction.

Case Number Two: A 28-year-old white male had complained for six months of decrease in size and force of his urinary stream. A severe urinary infection associated with stenosis of the urethral meatus was noted. White coalescent papules covered the surface of the glans penis. The disease process surrounded and extended into the urethral meatus and fossa navicularis as a firm, non-tender thickened

From the Department of Urology, Memorial Hospital of Chatham County, Savannah, Georgia.

replacement of normal mucosal tissue. The treatment of choice was wide urethral meatotomy. The incised meatus was anchored laterally to the corona of the glans penis by 000 chromic catgut sutures to prevent the apposition of the cut edges. Topical applications of steroid cream two to three times daily aided in the healing process.

Balanitis xerotica obliterans affects the glans penis in the second or third decades of life. The disease has no relationship to circumcision. The white, firm, coalescent papules or plaques are diffusely spread over the glans penis usually around and within the meatus and fossa navicularis.^{5,6} Of the 12 patients that have been treated during the past five years, satisfactory response has been gained from wide meatotomy and the application of a non-water soluble steroid cream.

Case Number Three

Case Number Three: A 56-year-old white male salesman noted five weeks following transurethral electroresection of the prostate gland, recurrences of what he thought were symptoms of prostatic obstruction characterized by frequency of urination, decrease in size and force of the urinary stream, nocturia and suprapubic discomfort. On examination he was found to have an almost impassable pinpoint urethral meatal stricture which was dilated with filiforms and followers. Urethral meatotomy was performed. He was instructed to use cotton applicators with non-water soluble steroidal cream applied to the urethral meatus and fossa navicularis several times daily. This method of treatment has been satisfactory.

While urethral meatal stenosis and urethral strictures occur in approximately 15 per cent of patients following transurethral prostatic resection, these complications follow other forms of prostatic surgery as well as simple urethral catheterization. The cause is primarily the formation of submucosal fibrous tissue

in the urethral wall with subsequent fibrotic contracture.⁷

Summary and Conclusions

Three patients have been presented to illustrate the most common types of urethral meatal stenosis. Congenital meatal stenosis is not uncommon. If aware of the inadequate caliber of the urethral meatus at the time of circumcision, a simple meatotomy can be performed. The meatal size should be calibrated at the time of pediatric examinations and if not felt to be adequate referred for meatotomy. Most pediatric patients with meatal disease are referred free of signs or symptoms by the astute pediatrician. Balanitis xerotica obliterans is not a rare disease. Many patients go untreated until irreparable damage has been done to either the lower and/or upper urinary tract. Recognition of the fibrotic nature of this collagen disease will lead to cure by simple meatotomy and the application of steroidal cream. Prostatectomy or simple urethral catheterization may result in urethral meatal stenosis which produces symptoms comparable to bladder neck obstruction. Wide meatotomy or dilatation of the urethral meatus followed by frequent applications of steroidal cream produces satisfactory results.

Memorial Hospital of Chatham County

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NEW MEDICAL PRACTICE UNITS 'PLANNING GUIDE' OFFERED BY AMA, SEARS-ROEBUCK

The American Medical Association, in conjunction with the Sears-Roebuck Foundation, has recently published a new planning guide for establishing medical practice units. Done on heavy vellum paper and consisting of 82 pages, the guide, of which there is only a limited supply, is available to any doctor. The guide contains suggestions on location, hospital and patient accessibility, size, property costs, shape and placement of building, climate, parking, landscaping, remodeling,

and a number of other important ideas regarding a medical office. Floor plans for each room needed in an office are given in black and white scale drawings and several suggested plans for two and three man offices are shown. Examples of "do-it-yourself" possibilities for medical practice facilities are illustrated along with lists of equipment and their prices. Doctors interested in obtaining the new planning guide should write to the Medical Association of Georgia Headquarters Office, 938 Peachtree St., N.E., Atlanta 9, Georgia.

EVALUATION OF METHYCLOTHIAZIDE THERAPY FOR ANGINA PECTORIS

Nanette Kass Wenger, M.D., Austin Flint,*
and Robert P. Wight, Jr.,* *Atlanta*

■ **No significant effect on incidence or severity of pain was noted.**

METHYCLOTHIAZIDE has been reported to decrease the incidence and severity of angina pectoris, apparently unrelated to its diuretic effect.¹⁻⁶ The postulated mechanism³ is a reduction of peripheral resistance, with a resultant decrease in cardiac work and myocardial oxygen requirement. This study was designed to evaluate the therapeutic efficacy of Methyclothiazide for angina pectoris.

Material and Methods

The study group consisted of 12 patients with stable angina pectoris, selected from the Cardiac Clinic of Grady Memorial Hospital. There were five females, two white and three Negro; and seven males, five white and two Negro; with an age range of 52 to 78 years. In 11 patients, angina pectoris was due to coronary artery disease and in one patient it was secondary to lumatic heart disease with aortic insufficiency. None of these patients had severe congestive heart failure or significant hypertension.

Evaluation of the incidence and severity of angina pectoris was determined by the number of Nitroglycerin tablets, grains 1/150, required for relief of pain during each 24-hour period; Nitroglycerin tab-

lets taken to prevent pain were not included in this recording.

Each patient was observed for a two-week control period, during which time record was made of the number of Nitroglycerin tablets taken therapeutically and prophylactically. A baseline determination was made of the systemic blood pressure, body weight, and serum electrolyte levels; an electrocardiogram was recorded. During each of four successive two-week periods, each patient was given, in addition to his usual therapy, either five mg. of Methyclothiazide** or a placebo tablet daily; any oral and diuretic previously administered was omitted. Drug or placebo tablet of a different code number was given for each two-week period; at no time did the investigators or the patients know whether drug or placebo was being administered. At the end of each two-week period of study, the systemic blood pressure, body weight, serum electrolyte levels—sodium, chloride, CO₂ and potassium, and electrocardiogram were recorded.

Results

In this manner 35 patient-periods on five mg. of Methyclothiazide and 13 patient-periods on placebo therapy were evaluated. During the study there was

* Senior student, Emory University School of Medicine.

This study was supported by a gift from Abbott Laboratories, Chicago, Illinois.

** Supplied as Enduron through the courtesy of Dr. George H. Berryman, Abbott Laboratories, Chicago, Illinois.

no significant change in systemic blood pressure, body weight, serum electrolyte values, or in the electrocardiogram.

In the group treated with five mg. of Methyclothiazide, seven patients reported a decrease in angina pectoris, 26 reported no significant change, and two patients had increased angina pectoris. In the placebo treated group, one patient had decreased angina pectoris, 12 reported no significant change in the pattern of angina pectoris, and none had increased angina pectoris.

Of interest is that seven of the eight instances of decreased angina pectoris were reported by two patients. Patient One had received five mg. of Methyclothiazide for all four study periods and reported decreased angina for three periods. Patient Two was treated with placebo for one study period and with five mg. of Methyclothiazide for three study periods; decreased angina pectoris was reported for all four study periods.

Statistical analysis, using the chi square method,

showed no significant difference between the drug treated and placebo treated groups.

Summary

In a group of patients with angina pectoris having neither severe congestive heart failure nor significant hypertension, five mg. of Methyclothiazide daily did not alter the incidence or severity of angina pectoris.

Emory University School of Medicine

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RADIATION FROM X-RAYS TAPED, COMPUTED AT EMORY UNIVERSITY

As a patient lies on the examining table during a fluoroscopic study, a recording device automatically punches holes in a paper tape.

The physician may change the position and size of the X-ray beam many times for better internal viewing, but every move is recorded. The tape is later fed into a computer which tells in a matter of seconds the total amount of radiation the body was exposed to and the size of the radiation field.

Duplication

Or, the tape can be used to duplicate the X-ray examination on a tissue-equivalent-plastic "phantom" of a man's torso. The "phantom" has dosimeters all over its body so that when it is X-rayed, exposure for certain of the body's organs can be measured.

These techniques have been developed by Emory University's radiology department. Physicist Perry Sprawls is now in charge of the project and works with engineer Bill Miller who has designed most of the equipment.

The recorder was developed at Emory several years ago, but it took one person half a day to do the 5,000 calculations that were necessary after the average examination until the computer program was developed for the project this year.

"The tape records five different things each second the X-ray is in use," Mr. Sprawls explains. "It tells whether the X-ray is on, the position of the X-ray tube both across and along the table, and describes the size and shape of the X-ray field."

So far the measuring system has only been used in fluoroscope examinations of the spine because the patient does not have to be rotated during the procedure. With even better recording equipment, however, it should soon be possible to measure radiation for almost any kind of examination.

Mr. Sprawls says the project is devoted entirely to finding out exactly how much radiation the patient received at a particular time—not in studying possible effects of radiation.

A Physician's Style

One use of the system will be to record different X-ray "styles" of physicians and to see whether these "styles" change with experience. This would be important in improving X-ray examination techniques. But in any case doctors will have a better idea of how much radiation they are subjecting their patients to.

The project is supported by grants from the National Institutes of Health to Dr. Robert Rohrer and Dr. H. Stephen Weens in the department of radiology.

1963 REVISED WORKMAN'S COMPENSATION AVERAGE SCHEDULE OF FEES

ON FEBRUARY 17, 1963, the Executive Committee of the Council of the Medical Association of Georgia gave tentative approval to a new schedule of average fees for Workman's Compensation with the recommendation that the Association Occupational Health Board refer the schedule to MAG Council with their recommendations.

At the subsequent MAG Council meeting March 23-24, 1963, the Council approved this new schedule of average fees on recommendation of the MAG Occupational Health Board. And officially on April 1, 1963, the State Board of Workman's Compensation adopted the new medical schedule of average fees.

So that the new schedule may be available to the physicians of Georgia, this 1963 revised schedule of average fees for the treatment and care of injured employees under this program is reprinted as follows:

AVERAGE FEE SCHEDULE FOR TREATMENT AND CARE OF INJURED EMPLOYEE MISCELLANEOUS

First Aid, without sutures.....	\$ 5.00
First Aid, requiring not more than five sutures.....	10.00
More Extensive Wounds	15.00
	and up
Office Visits (Subsequent), with Dressings.....	4.00
Home Visits	10.00
Hospital Visits	5.00
Night Office Visits—6 P.M. to Midnight (Plus First Aid)	10.00
Night Office Visits—Midnight to 7 A.M. (Plus First Aid)	15.00
Physical Therapy	
When given by a Registered Physical Therapist or Physician	5.00
(The office visit shall be included in this charge)	
All office visits requiring physical therapy, diathermy, heat packs, ultra-sonic, massage and any other heat or manipulative procedure, when not given by a Registered Physical Therapist or Physician, shall be included in the charge for office visit.	
Tetanus Antitoxin, Prophylactic—with Skin Test.....	3.00
Tetanus Toxoid	2.00

Multiple injuries or those requiring extensive surgical dressings, or cases requiring unusual, extraordinary and abnormal after care, the physician will be entitled to additional fees for such proportion of the after care treatment that is in excess of the after care treatment in usual, ordinary and normal cases. Said additional fees for such excess of after care treatment shall be by authorization and arrangement established by agreement between the physician and insurance carrier or employer.

Anesthesia—Fees shall be on the basis of usual hospital charges in the community.

Laboratory—All examinations shall be on the basis of usual hospital charges in the community.

OPERATIONS—USUAL TYPE AFTER CARE INCLUDED IN FEE UNLESS OTHERWISE INDICATED

Exploratory Laporotomy	\$150.00
Hernia	
Herniorraphy, Single	150.00
Herniorraphy, Double	200.00
Hernia, Recurrent	175.00
Hernia, Strangulated—Without Resection of Bowel...	175.00
Hernia, Strangulated—With Resection of Bowel.....	225.00
Removal of Spleen, Kidney, Bladder or other abdominal viscera	225.00
Rupture of Kidney, requiring drainage only.....	140.00
Orchidectomy	85.00
Epididymectomy	85.00
Ruptured Urethra, requiring operation.....	150.00
Ruptured Viscus	200.00
Skull fracture, requiring decompression only.....	200.00
Head Injury, requiring craniotomy	275.00
Cervical Laminectomy	350.00
Lumbar Laminectomy	300.00
Tendonorrhies	
Extensor Tendons (One) (After Care Extra).....	40.00
Each additional Tendon (After Care Extra).....	25.00
Flexor Tendons (One) (After Care Extra).....	100.00
Each additional Tendon (After Care Extra).....	50.00
Cystoscopy	25.00
Abscess, Incision and Drainage (After Care Extra).....	10-25.00
Foreign Body, Removal (After Care Extra).....	15-35.00
Burns, Severe (After Care Extra).....	25-50.00
Assistant's Fee	25-50.00

X-RAY EXAMINATIONS

Upper Extremities:		Abdomen:	
Fingers	\$ 7.50	Flat Plate	\$10.00
Hand	8.50	Flat Plate & Upright	15.00
Hands (Both)	15.00	I. V. Pyelogram	25.00
Wrist	10.00	Cholecystogram	20.00
Forearm	10.00	Esophagram	15.00
Wrists (Both)	15.00	G. I. Series	25.00
Elbow	10.00	Barium Enema	25.00
Humeral		Spine:	
(Below Shoulder) ..	10.00	One Section	
Shoulder (1 View) ..	11.50	(AP&Lat)	20.00
Shoulder (2 Views) ..	15.00	Two Sections	30.00
Lower Extremities:		Complete Spines	50.00
Toes	7.50	Sacro-iliac Joints	15.00
Foot	8.50	Head:	
Feet (Both)	15.00	Routine Skull Films ..	20.00
Foot and Ankle	15.00	Skulls with Stereo	25.00
Ankle	10.00	Maxilla or Mandible	
Leg	10.00	(1)	15.00
Legs (Both)	15.00	Maxilla or Mandible	
Knee	11.50	(both)	25.00
Femur	11.50	Mastoids	25.00
Hip (2 Views)	15.00	Sinuses	15.00
Pelvis (& Lat. Hip) ..	17.00	Nasal Bones	15.00
Chest:		Eye:	
Lung Fields (1 View) ..	10.00	To determine foreign	
Lung Fields		body	11.50
(2 Views)	15.00	Localization of	
2 Views with		foreign body	25.00
Fluoroscopy	20.00		
Fluoroscopy Only	10.00		
Ribs	15.00		

ORTHOPEDIC SCHEDULE DISLOCATIONS

Where the reduction of a dislocation is done at the time and place of first attention, the reduction of the dislocation shall be presumed to include the first aid charge and no additional first aid charge will be allowed.

In each case after care is extra with the exception of hospital visits subsequent to surgery.

Finger or Toe (Chip Fractures of Distal Phalanx)	\$ 5.00
Finger or Toe (Other than Above)	15.00
Carpal Bones	60.00
Tarsal Bones	60.00
Elbow	50.00
Shoulder	50.00
Patella	35.00
Hip	85.00
Jaw	30.00

Where open reduction is necessary the fee should be doubled.
Subsequent cast changes as in cast change schedule.

FRACTURES

Where the reduction of a fracture is done at the time and place of first attention, the reduction of the fracture shall be presumed to include the first aid charge and no additional first aid charge will be allowed.

In each case after care is extra with the exception of hospital visits subsequent to surgery.

Fingers or Toes (Chip Fracture of	
Distal Phalanx Only)	\$ 5.00
Fingers or Toes (Other than Above)	20.00
Metatarsals or Metacarpals	35.00
Carpal or Tarsal Bones	50.00
Oscalcis	100.00
Colle's or Smith Fractures	65.00
Radius	55.00
Ulna	55.00
Forearm (Both Bones-Shaft)	75.00
Humerus	75.00
Clavicle	35.00
Scapula	35.00
Tibia	75.00
Fibula	30.00
Lower Leg (Both Bones)	100.00
Patella	50.00
Femur	100.00
Pelvis (Requiring Bed Rest Only)	25.00
Pelvis (Requiring Traction)	100.00
Spine (Requiring Brace or Bed Rest Only)	50.00

Spine (Requiring Spica Cast)	125.00
Coccyx or Sacrum	25.00
Facial Bones, Nose, Etc. (Requiring manipulation)	30.00
Facial Bones, Etc. (Not requiring manipulation)	10.00
Jaw	35.00
Jaw (With wiring or Ext. Fixtures)	75.00
Compound fractures 50% in addition to usual fee.	
Where open Reduction is necessary the fee should be doubled.	
Subsequent cast changes as in cast change schedule.	

ORTHOPEDIC OPERATIONS

After care is extra with the exception of hospital visits subsequent to surgery.

Amputations:

Finger or Toe (One)	\$ 50.00
Each additional Finger or Toe	30.00
Arm or Forearm	100.00
Hand	100.00
Shoulder	125.00
Leg	100.00
Thigh	100.00
Hip	175.00
Foot	125.00

Fusions:

Wrist	250.00
Shoulder	250.00
Ankle	250.00
Knee	250.00
Hip	300.00
Spine	300.00

Spine Fusion and Laminectomy

(If performed at same time)	500.00
Subastragular or Tripe Arthrodesis	250.00
Fractures of Femoral Neck requiring Nailing	250.00
Inter-Trochanteric Fractures requiring Nailing	300.00
Osteotomy of Femur, Below Hip	150.00
Osteotomy of Femur, Involving Hip	250.00
Repair of Torn Rotator Cuff	200.00
Operation for Calcified Tendonitis, of Shoulder	100.00
Excision of Bursae, Prepatellar, Olecranon	75.00
Excision of Small Bursae	35.00
Excision of Semi-Lunar Cartilage of Knee	150.00

Bone grafts and operations for osteomyelitis, fee shall be by agreement between physician and insurance carrier or employer.

Charges for any item of Medical or Surgical procedure or care not listed herein are to be reasonable and determined by arrangement and agreement between physician and insurance carrier or employer.

CAST CHANGES

Forearm or Short Leg Casts	\$ 10.00
Full Arm or Long Leg Casts	15.00
Shoulder Spica	40.00
Hip Spica	50.00
Body Spica	50.00
Minerva Jacket	65.00

EYE CONDITIONS

Ordinary removal of foreign body:

A. Attached to cornea or conjunctiva	
(simple embedded)	\$ 7.50
B. Deeply embedded in cornea or conjunctiva	
(requiring use of Spud)	10.00
Localization of foreign body inside the eyeball,	
when necessary, X-Ray	25.00
Extraction of foreign body from inside the eyeball,	
(Anterior Chamber) with or without magnet, including	
after care	90.00
Sclerotomy and extraction of foreign body from inside	
the eyeball (Posterior Chamber) with or without	
magnet, including after care	135.00
Enucleation or evisceration of eyeball, with or without	
implant, including after care	110.00
Suture of sclera and/or cornea for perforating wound,	
including after care	100.00
Iridectomy, including after care	100.00
Repair or iris prolapse, with suture or cornea and/or	
sclera including after care	125.00
Extraction of traumatic cataract, unilateral, including	
iridectomy and after care	135.00
Extraction of traumatic cataract, bilateral, including	
iridectomy and after care	225.00
Reattachment of retina (trans-scleral diathermy, scleral	

SPECIAL ARTICLE / Continued

shortening or folding, vitreous implant) including after care	175.00
Surgery on extra-ocular muscles for correction of diplopia or ptosis as result of trauma, including after care.....	175.00
Keratoplasty, corneal transplant, including after care....	200.00
Exploration of orbit	By Agreement
Plastic repair of eyelid.....	By Agreement
Cauterization of corneal ulcer	10.00
Incision and drainage of abscess of eyelid, including chalazion	15.00
Tarsorrhaphy, including after care	50.00
Suture of eyelids and/or conjunctiva (1-5 sutures).....	15.00
Suture of eyelids and/or conjunctiva (Over 5 sutures)...	25.00
Complete ophthalmological examination and report:	
A. Excluding visual fields	15.00
B. Including visual fields.....	25.00
Refraction, when authorized by the commission.....	15.00

Office visits \$5.00 per visit after removal of deeply embedded foreign body, not to exceed more than four visits, \$4.00 thereafter.

Home visits	10.00
Hospital visits	5.00

EAR, NOSE AND THROAT CONDITIONS

Complete examination of ears, for hearing, including audiometer test	\$ 20.00
Ruptured ear drum, first visit.....	15.00
Additional visits	4.00
Mastoidectomy, unilateral, including after care.....	150.00
Mastoidectomy, bilateral, including after care.....	200.00
Deviated septum, including after care.....	100.00
Bronchoscopy, removal foreign body	125.00
Tracheotomy, after care extra	75.00

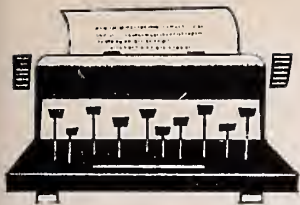
Charges for any item of Medical or Surgical procedure or care not listed herein are to be reasonable and determined by arrangement and agreement between physician and insurance carrier or employer.

ALTHOUGH the number of speeches made by Georgia doctors to the lay public during the month of May does not exceed the fine presentation of 13 stars on the April map, the results are more encouraging each month. This month shows eight stars, the larger ones indicating more than one talk given. In Brunswick and Atlanta four speeches were presented in each city and Griffin and Savannah doctors spoke to two lay groups each.

Things are improving, no doubt about it, but it is the hope of the Medical Association of Georgia that this is just the beginning.

How well are we telling our story?





Typhoid Fever

THE EPIDEMIC OF TYPHOID FEVER in Zermatt, Switzerland, and the recent report of a case in Atlanta serve as a reminder that this disease continues to be a threat and that constant vigilance is necessary for effective control. It was not too many years ago that typhoid fever was one of the most serious and prevalent infections in the United States. Epidemics occurred annually, usually in September, and the wards of the hospitals were full of such cases. Improved methods of sanitation together with prompt detection and management of carriers have produced a sharp progressive decline in the incidence of typhoid fever. For example, 2,169 cases were reported in the United States in 1954 in contrast to 814 in 1961. Another striking feature has been the decrease in mortality rate from 12 per cent to about two per cent since the introduction of chloromycetin in treatment.

Source of Infection

Formerly, the typhoid patient was the important source of infection, spreading the disease by fecal contamination usually of water or milk supplies. At the present time the carrier is almost the sole source of infection. It is an interesting fact that the typhoid carrier may never have had manifest signs of the disease, thus making the problem of detection more difficult. The carrier is particularly dangerous as a food handler. Although any type of food may become contaminated by a carrier, milk and milk products, fresh fruit and vegetables and raw shell fish are the most important vehicles.

The typhoid problem in this country is well il-

lustrated by recent experiences with contaminated oysters. During the last three months of 1961 a series of six cases of typhoid fever occurred in Florida, Georgia and Alabama, which were related to raw oyster consumption. Subsequent investigation revealed that the oysters came from the same shucking plant. This plant was found to be contaminated by a previously unknown typhoid carrier, a 67-year-old oyster tonger who worked alone and sold oysters exclusively to this processing plant.

Control

The control of typhoid fever is almost exclusively that of detection and management of the carrier. The need for supervision of food handlers and prompt investigation of each case is obvious. The detection of carriers requires expert epidemiological investigation, screening of food handlers and suspected individuals for serum Vi hemagglutinins, and finally isolation of the typhoid bacillus from the feces. Cholecystectomy remains the most effective method of eradicating the carrier state. Immunization with killed typhoid vaccines is of unquestioned value in military groups, but their routine use in the general population is a controversial subject. Certainly all would agree that immunization is a poor substitute for sanitary control measures. It seems advisable at the present time to concentrate our immunization efforts against those diseases for which effective procedures are available such as tetanus, poliomyelitis, smallpox, diphtheria, and measles.

William F. Friedewald, M.D.

"See You In Atlantic City"

George M. Fister, M.D.

President

American Medical Association

THE AMERICAN Medical Association will hold its 112th annual meeting June 16-20 at Atlantic City. In urging you to attend, I would like to write briefly about an aspect of science that is rapidly becoming a very serious problem. I refer to what scientists have called "The Publication Explosion"

"Publish or Perish"

Research men are faced with the dictum of "publish or perish." Naturally, they publish. They publish so much that some areas of science now have such a volume of literature that it is often cheaper and faster to repeat an experiment than to search the literature and find out what others have done in the same field.

It has been said that it would be necessary for a physician to read one book an hour just to keep up with new findings in his own specialty. This obviously is impossible.

There were four million scientific documents published in 1962. These included some three million papers and articles in some 70 thousand technical and professional journals. The bulk of these are in the life sciences, particularly medicine. They are published in at least 65 different languages, in almost every country of consequence in the world.

Faced with this overwhelming deluge of paper, the physician in practice, already one of the busiest men in his community, may be inclined to just throw up his hands.

The scientific meeting helps greatly to fill the gap and to help the physician keep abreast of new developments. At the AMA annual meeting, in a short space of four or five days the physician has his choice of literally hundreds of scientific papers covering the broad spectrum of medicine. He can select half a dozen lectures daily from the program as a whole. Or he can concentrate on his specialty section and its meetings.

The physician can select outstanding medical motion pictures, fresh from the production line. Or he can view live telecasts of surgery and medicine in action in new areas.

It would take years of reading an hour a day to learn all that can be learned in five days at the annual meeting of the American Medical Association. The scientific exhibits alone are a good post-graduate course in medicine.

Keeping Abreast

All of us as physicians are well aware of the problems of keeping abreast, of bringing the findings of the researchers into our practice as soon as possible. Through the annual meeting of our national association, we can make considerable progress in this important respect.

As president of the American Medical Association, I personally urge every American physician to make plans now to attend this annual meeting June 16-20 in Atlantic City.

The Identification of "Pseudoneurotic" or "Borderline" Schizophrenic Patients in General Medical Practice

THE TERM "SCHIZOPHRENIA" was coined in 1911 by Bleuler¹ to refer to a group of "diseases" (as he conceived of them) characterized by a disturbance in the normal associations that constitute rational adult thinking, an effect either flattened or inappropriate to the subject matter at hand, a tendency to autistic reveries, and a striking ambivalence of feelings manifested in interpersonal relationships.

Little Progress Made

Regrettably, since the time of Bleuler there has been little basic progress made on the nosology of the group of schizophrenias. However, one clinical entity which is of considerable importance to all physicians, has been delineated, beginning with the work of Hoch and Polatin². Among patients who do not obviously show the characteristics mentioned above but who still may be labeled "schizophrenic," there are some who get along outside the walls of the mental hospital and, although at times they may show the obvious characteristics of schizophrenia, usually show instead a variety of often bizarre and puzzling neurotic and psychosomatic symptoms. The presence of the latter symptoms tends to bring these patients into the office of every kind of physician and to present what seems to be a baffling diagnostic problem. These patients may undergo numerous exploratory workups performed in good faith by a physician trying to make sense out of a variety of bizarre and changing complaints that at times seem to resemble classical medical illnesses and at times seem to be something esoteric or some occult disease. The final diagnosis of schizophrenia is often not made until the patient is observed accidentally during a period when he is showing the obvious signs of the illness, or when patient and physician have been mutually exhausted to no avail and it gradually becomes apparent that there is something "mentally wrong" that is leading to the various complaints.

Variety of Symptoms

This group has been called by a number of names including "pseudoneurotic schizophrenia" because they present such a variety of neurotic symptoms,

(and sometimes also a variety of sociopathic and behavior disorders including delinquency, alcoholism and addiction) or more correctly "borderline schizophrenia" indicating they are often on the verge of frank schizophrenia. Through the use of the various neurotic sociopathic and psychosomatic symptoms, these patients seem to be protecting themselves against the frank schizophrenia.

On the other hand, there is a certain peculiar stability to these patients. They can shift from symptoms to symptoms without ever showing frank breakdown and it is not necessarily characteristic for them to eventually break down and become overtly schizophrenic. In fact, this feature of stability has raised the question of whether this group should be etiologically differentiated from classical schizophrenia, a question that cannot be answered sensibly at this time.

There are certain signs which can help the practicing physician identify these patients and therefore save the patient and himself many needless procedures and frustrations, and facilitate referral for psychiatric treatment. First of all, most characteristically, these patients present any variety of symptoms and complaints which may or may not sound like true medical illness, may be any type of severity, and may suddenly change in nature and description.

"Borderline" Schizophrenia

Knight³ suggests certain "macroscopic" and "microscopic" indications of "borderline" schizophrenia. The macroscopic signs are: lack of concern about the realities of their life predicament associated with grossly inappropriate treatment proposals of the patient's own; presence of multiple symptoms and disabilities often viewed as being due to malevolent external influences; lack of achievement over a long period of time in social, personal, as well as work spheres; poor planning for the future with respect to these various spheres; lack of attention to the ordinary routine of looking after or grooming themselves; and bizarre dreams with difficulty in separating the dreams or nightmares from reality.

The "microscopic" signs, detectable upon speak-

ing at length with the patient, are: peculiarities of word usage, blocking in speech or thought processes, contamination of idioms, arbitrary inferences, inappropriate effect, suspicion laden behavior often accompanied by embarrassed apology, and obliviousness to obvious implications of statements such as in jokes, etc.

Since none of these signs taken in themselves can make the diagnosis, it is obvious that getting to know the patient is mandatory before an accumulation of these various signs begins to point to a diagnosis. Therefore, the spending of some office time in talk-

ing to the patient and getting to know him may save a tremendous amount of time later on, and save the patient from needless medical and surgical procedures.

Richard D. Chessick, M.D., Chicago, Illinois

Dr. Chessick is Chief of Psychiatry, Veterans Administration Research Hospital and Assistant Professor of Psychiatry, Northwestern University Medical School.

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3. Knight, R. P.: Diagnosis of Borderline States, *Bull, Menninger Clinic*, 17:1-2 and 139-150, 1953.

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

Name	Address	Classification	County Society
Blasingame, John T., Jr.	239 Auburn Avenue, N.E. Atlanta 3, Georgia	Active	Fulton
Brannon, Lawrence T.	340 Boulevard, N.E. Atlanta 12, Georgia	Active	Fulton
Brown, Leonard	1208 Church Street Marietta, Georgia	Active	Cobb
Curtis, Earnest M., Jr.	Emory University Clinic Atlanta 22, Georgia	Active	Fulton
Deas, Ralph H.	3166 Maple Drive, N.E. Atlanta 5, Georgia	Active	Fulton
Eubanks, Omer L.	Roswell, Georgia	Active	Fulton
Garrettson, Lorne K.	488 Burlington Road, N.E. Atlanta 7, Georgia	Service	Fulton
Gilson, Albert J.	Emory University Medical School Department of Radiology Atlanta 22, Georgia	Active	Fulton
Grady, Charlotte	2025 Peachtree Road, N.E. Atlanta, Georgia	Service	Fulton
Hendrix, Vernon J.	300 Boulevard, N.E. Atlanta 12, Georgia	DE 2	Fulton
Holloway, Emory W., Jr.	25 North Elm Street Commerce, Georgia	Active	Jackson-Barrow
Holton, John B.	35 Butler Street, N.E. Atlanta, Georgia	Active	Fulton
James, Walter S.	1293 Peachtree Street, N.E. Atlanta, Georgia	Active	Fulton
Knight, Lee J.	Cherokee Medical Building Smyrna, Georgia	Active	Cobb
Korndorffer, William E.	Griffin Spalding County Hospital Griffin, Georgia	Active	Spalding
Lawrence, George C.	1951½ Auburn Ave., N.E. Atlanta 3, Georgia	Active	Fulton

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA (Continued)

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Lester, Jess C.	478 Peachtree Street, N.E. Atlanta 8, Georgia	Active	Fulton
Levin, Spencer Ely	5444 Peachtree Industrial Boulevard Chamblee, Georgia	Active	Fulton
McMurray, Arthur A.	1161 Main Street Forest Park, Georgia	Active	Fulton
Mattison, Richard C.	1364 Clifton Road, N.E. Atlanta 22, Georgia	DE 2	Fulton
Merritt, George W.	110 Jackson Street Vidalia, Georgia	Active	Southeast Georgia
Moorhead, Christian R.	236 Auburn Avenue, N.E. Atlanta, Georgia	Active	Fulton
Mostellar, Marvous E.	1010 Medical Arts Building Atlanta 8, Georgia	Active	Fulton
Palmer, Henry G., Jr.	24 Fourteenth Street, N.E. Atlanta 9, Georgia	Active	Fulton
Ramirez, Raimundo J.	300 Boulevard, N.E. Atlanta 12, Georgia	Active	Fulton
Rose, A. McKoy, Jr.	1416 Cherokee Street Marietta, Georgia	Active	Cobb
Scamman, W. Wike	Kennestone Hospital Marietta, Georgia	Active	Cobb
Staats, Ethan F.	1817 Colland Drive, N.W. Atlanta, Georgia	DE 2	Fulton
Stewart, William W.	319 West Lake Avenue, N.W. Atlanta 18, Georgia	Active	Fulton
Stuart, Carlos A.	46 5th Street, N.E. Atlanta 8, Georgia	Active	Fulton
Taylor, Clarence F., Jr.	300 Boulevard, N.E. Atlanta 12, Georgia	Active	Fulton
Taylor, Robert P.	Church Street Grantville, Georgia	Active	Fulton
Thomas, Charles B.	47 Jefferson Street Newnan, Georgia	Active	Fulton
Warner, Clinton E.	312 W. Lake Avenue, N.W. Atlanta 18, Georgia	Active	Fulton

COLLEGE OF PHYSICIANS DESIGNATES GEORGIA DOCTORS

Georgia doctors recently designated as Fellows of the American College of Physicians are: Drs. Lamar B. Peacock, John G. Wilmer, and Robert C. Schlant, all of Atlanta; and Dr. William P. Roche, Jr., of Dublin.

Elected as Associates were: Dr. Joseph N. Berry, of Atlanta; Dr. Charles J. Zerzan, Jr., (Maj., USA), of

Fort Gordon; Dr. Mason G. Robertson, of Savannah; and Dr. Stacy H. Story, Jr., of Valdosta.

The Fellowship honors were formally bestowed April 4, 1963, in Denver, Colorado, at convocation ceremonies held in conjunction with the 44th Annual Session of the American College of Physicians.

1963-64 CALENDAR OF MEETINGS

State

April 14-June 9—Seminars on the fundamental mechanisms of disease sponsored by the Independent Non-Profit Hospitals of Atlanta: June 9—"Virology; Its Background in Current Clinical Concepts."

September 20-21—Georgia Heart Association, Fifteenth Annual Meeting and Scientific Sessions, Biltmore Hotel, Atlanta.

September 30-October 4—"Five Days of Internal Medicine," sponsored by the Department of Medicine, Emory University School of Medicine, Atlanta.

May 3-6, 1964 — 110th Annual Session of the Medical Association of Georgia, Macon, Ga.

Regional

May 16-19—Florida Medical Association, Diplomat Hotel, Hollywood-By-the-Sea, Fla.

May 27-29—American Ophthalmological Society, The Homestead, Hot Springs, Va.

June 24-27—American Orthopaedic Association, The Homestead, Hot Springs, Va.

August 22-24 — Sixteenth Annual Postgraduate Obstetric-Pediatric Seminar sponsored by the Children's Bureau and the state health departments of Georgia, South Carolina, Mississippi, Alabama, and Florida, Riviera Beach Hotel, Daytona Beach, Fla.

September 5-7—American Association of Obstetricians and Gynecologists, The Homestead, Hot Springs, Va.

October 6-9—Medical Society of Virginia, Roanoke Hotel, Roanoke, Va.

October 10-13—American Society of Maxillofacial Surgeons, Sheraton-Park Hotel, Washington, D. C.

October 13-18—International Congress of Plastic Surgery, Sheraton-Park Hotel, Washington, D. C.

October 20-23—American College of Gastroenterology, Shoreham Hotel, Washington, D. C.

October 27—Association of Clinical Scientists, Statler-Hilton Hotel, Washington, D. C.

November 7-9—Conference on Obstetric, Gynecologic, and Neonatal Nursing sponsored by District Four, Washington, D. C.

November 8-9—Southern Society for Pediatric Research, St. Jude Hospital, Memphis, Tenn.

November 18-21—Southern Medical Association, New Orleans, La.

National

May 27-31—Five Day Refresher Course in Pediatrics for Pediatricians and General Practitioners, The Children's Hospital of Philadelphia, Philadelphia, Pa.

June 3-21—Forty-eighth Session of the Trudeau School of Tuberculosis and Other Pulmonary Diseases, Saranac Lake, N. Y.

June 13-17—Twenty-ninth Annual Meeting of the American College of Chest Physicians, Atlantic City, N. J.

June 16-20—American Medical Association Annual Meeting, Atlantic City, N. J.

July 15-19—Second International Conference on Congenital Malformations sponsored by The National Foundation—March of Dimes, Americana Hotel, New York City.

August 26—Annual Meeting of the American Academy of Physical Medicine and Rehabilitation, Sheraton-Dallas Hotel, Dallas, Tex.

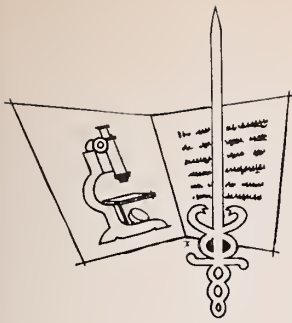
September 15, 1963-June 15, 1964—Nine month tutorial program in Cardiology offered by the Institute for CardioPulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

October 5-11—Annual Otolaryngologic Assembly sponsored by the Department of Otolaryngology of the University of Illinois College of Medicine and the Illinois Eye and Ear Infirmary.

October 11-15—Eighth International Congress on Diseases of the Chest sponsored by the Council on International Affairs of the American College of Chest Physicians, Mexico City, Mex.

October 17-19—Clinical Neuropsychiatric Association, Sheraton-Lincoln Hotel, Houston, Tex.

October 21-22—American Cancer Society, Scientific Session, Conference on Unusual Forms and Aspects of Cancer in Man, Biltmore Hotel, New York City.



LEUKEMIA

Charles M. Huguley, Jr., M.D., *Atlanta*

LEUKEMIA is an increasingly important illness. The incidence in all age groups, particularly in children, has been steadily increasing. It is estimated that in 1963 leukemia will account for 13,800 deaths in the U. S., about 2700 of them in children and over 200 deaths in Georgia. It causes more deaths of children ages four to 14 years than any other disease.

Sensitivity to Chemotherapy

Another important aspect of leukemia is the sensitivity of all types to modern chemotherapeutic agents. It is seldom that a case of leukemia is not definitely affected by therapy, and it is not unusual in any type of leukemia for therapy to lead to a complete disappearance of all diagnostic evidence of the disease. There is a firm basis for hope that a slightly more potent agent or a combination of agents might eventually lead to cure. This sensitivity to chemotherapeutic agents makes the leukemias as a group the most valuable diseases for the study of new anti-cancer drugs. The leukemias are also the leading area of research into the viral etiology of cancer.

There are three major categories of leukemia: 1. acute leukemia, 2. chronic myeloid leukemia, 3. chronic lymphocytic leukemia. While there are other rather bizarre forms of leukemia, they do not occur frequently.

Acute Leukemias

All acute leukemias are basically similar whether the cell type is the stem cell, the lymphoblast, the myeloblast or the monoblast. The onset may be insidious over a number of weeks but is usually quite rapid. The symptoms are those of pallor and weakness attributable to anemia, fever sometimes due to the illness but usually due to a superimposed infec-

tion, and a bleeding tendency due to lack of platelets. Lymph nodes, spleen and liver may or may not be enlarged. By the time the patient reaches the doctor there is usually a moderate or severe anemia and thrombocytopenia. The white count is elevated in about half the cases but is often normal or even low. Careful examination of the blood smear will nearly always reveal the presence of abnormal blast cells and usually there is a striking number of these. Even if there is a high white count with many blast cells in the blood, it is mandatory that a marrow examination be done to corroborate the diagnosis of this very serious disease.

Great Strides

Great strides have been made in the treatment of acute leukemia in children in the last 15 years. Whereas fewer than ten per cent of children with acute leukemia lived as long as 12 months prior to the use of the present agents, we now obtain considerable improvement in practically all children and over half of them live longer than 12 months. The response of adult patients is much less satisfactory and no more than one in ten has a really good remission. The cortisone derivatives have a most dramatic effect in acute lymphoblastic leukemia in children and can be used to effect rapid improvement with minimal deleterious effects. The response is short-lived, and these drugs are not recommended as agents for continuous use. They are much less effective in myeloblastic leukemia and monoblastic leukemia. The anti-purine drug, 6-mercaptopurine (Purinethol), is the choice for treatment in adults or children. Once the disease has become resistant to 6-mercaptopurine, an anti-folic drug, usually methotrexate, may produce a second remission—often in children, but seldom in adults.

The course of acute leukemia is punctuated by serious infections which are often difficult to diagnose and which require prompt and vigorous antibiotic therapy. Transfusions are used to maintain the hemoglobin at a level of about nine grams. In the case of severe bleeding, fresh, concentrated platelets may be very helpful.

Insidious Onset

Chronic myelocytic leukemia usually begins insidiously, and the patient presents either with weakness due to anemia or with the complaint of a palpable mass in the left upper quadrant. At this time the spleen is usually moderately to strikingly enlarged. The liver is usually palpable. There is often tenderness over the sternum. There is usually a moderate anemia. Such changes seldom take place until the white count has exceeded 100,000. If they are present with a white count less than 100,000, one should suspect that the patient has myelofibrosis rather than chronic myelocytic leukemia. The platelet count is often high. The differential shows the characteristic left shift. This illness can be treated effectively with a variety of agents including X-ray therapy, alkylating agents such as chlorambucil (Leukeran) or busulfan (Myleran) or 6-mercaptopurine (Purinethol). However busulfan produces much more effective control of the symptoms and signs of the disease and induces longer remissions than the other drugs.

Regardless of how well the patient responds initially, there will almost always be a rather sudden development of a "blast phase" after three to five years with a subsequent course similar to that of acute myeloblastic leukemia. This is difficult to treat. Some patients respond to 6-mercaptopurine or to

Demecolcin (a colchicine derivative) but most patients do not.

Chronic Lymphatic Leukemia

Chronic lymphocytic leukemia nearly always has an insidious onset. Many cases are diagnosed by a routine blood count done while investigating some other illness. The lymph nodes and spleen are usually moderately enlarged though not always. The patient may have no evidence of disease other than the elevated white count with lymphocytosis or there may be a severe suppression of all normal blood cells. Chronic lymphocytic leukemia should not be treated unless the patient has some disability due to the disease such as anemia, thrombocytopenia, progressive enlargement of nodes, painful lymph nodes or spleen, persistent unexplained malaise or weight loss. When the patient does require treatment, the best currently available drug is chlorambucil. This drug should be administered cautiously in doses adjusted so as to achieve the maximum control of the disease which seems obtainable without serious depression of the marrow. The drug is then discontinued until the above listed indications for treatment recur. Eventually most patients will require fairly continuous treatment. There is a broad spectrum of clinical course in chronic lymphocytic leukemia. Although some patients may get along well for 15 or 20 years there are many others who do very poorly and seem to respond little or not at all regardless of treatment given. The average survival is probably in the neighborhood of four years at this time. An important and frequent complication is hemolytic anemia with a positive Coombs' test. This is often successfully managed with the use of corticosteroids. Another frequent complication is hypogammaglobulinemia with increased susceptibility to infection. This may be helped by regular administration of human gamma globulin.

Emory University Hospital

Approved by the Professional Education Committee, Georgia Division, ACS.

LOCAL PATHOLOGISTS NAMED DIPLOMATES BY AMERICAN BOARD OF PATHOLOGY

The American Board of Pathology recently named seven Georgia doctors as Diplomates.

This certification is given after a pathologist has met the highest standards of the medical specialty of pathology, with a minimum of four years of training and experience after getting his M.D. degree.

Certification is given in seven classifications of pathology. The principal classifications are anatomic pathology and clinical pathology. The others are the

special fields of forensic pathology, neuropathology, hematology, clinical chemistry, and clinical microbiology. Many pathologists ultimately attain certification in two or three classifications.

Following are the Georgia doctors honored: Dr. Jenaro S. Asteinza, Milledgeville; Dr. Michael S. Buckner, Albany; Dr. Robert B. Hornberger, Atlanta; Dr. Robert M. Howard, Savannah; Dr. Willis S. Hoch, Fort McPherson; Dr. William E. Korndorffer, Jr., Atlanta; and Dr. William B. Mullins, Augusta.



PAROXYSMAL TACHYCARDIAS IN INFANTS

Nanette Kass Wenger, M.D., *Atlanta*

PAROXYSMAL TACHYCARDIA, estimated to occur once in every 25,000 children, is a more critical problem in infancy than in the adult age group. Prompt and accurate diagnosis and therapy are mandatory to prevent severe congestive heart failure, cardiovascular collapse, and death.

Paroxysmal tachycardia has its greatest incidence in the first four months of life, with males being predominantly affected. Particularly in this age group, the etiology is often unknown and the infant has an apparently normal heart. Factors predisposing to paroxysmal tachycardia include congenital heart disease especially (Ebstein's disease), the Wolff-Parkinson-White syndrome, childhood infections, rheumatic heart disease, sinus node tumors, skull fracture, chest trauma, digitalis intoxication, etc.; paroxysmal tachycardias are often precipitated by cardiac catheterization, anesthesia, and surgery.

Clinical Picture

The younger the child and the more rapid the ventricular rate, the more likely the child is to be critically ill; the dramatic signs and symptoms are most often erroneously diagnosed as pneumonia. There is commonly a history of restlessness, irritability, failure to nurse, and vomiting. The infant appears pale, cold and clammy, with slight cyanosis of the lips and nailbeds. Respiration is rapid and labored, occasionally associated with cough. The pulse is weak and rapid. The child may be febrile, and transient murmurs are heard. Hepatomegaly, facial and peripheral edema, and rales in the chest may be present.

The onset of congestive heart failure, more com-

mon in the younger age group, seems dependent on the heart rate and the duration of the tachycardia. Congestive heart failure rarely occurs with a ventricular rate under 200/min. and a tachycardia of less than 24 hours duration. Nadas describes congestive heart failure in one-fifth of the patients after 36 hours of tachycardia and in one-half of the children after 48 hours.

Associated laboratory abnormalities may include an elevated white blood count and cardiomegaly with congested lung fields on X-ray examination. In addition to the arrhythmia, the electrocardiogram may have an abnormal T wave configuration, persisting for several weeks after subsidence of the tachycardia.

Supraventricular Tachycardia

Paroxysmal tachycardias, characteristically sudden in onset, vary in duration from minutes to years, usually subsiding within a few hours or days. Identification of the specific type of arrhythmia depends on the electrocardiogram. Supraventricular tachycardia, the most commonly encountered arrhythmia, was reviewed by Hubbard in 1941; he described the resultant clinical syndrome in infancy. The heart rate in supraventricular tachycardia is rapid and regular, varying between 250 and 300/min., with the arrhythmia having an abrupt onset and termination, at times reverting with vagal stimulation. P waves may be identified on the electrocardiogram, although this is often difficult. Ventricular conduction is normal and T wave abnormalities, secondary to the tachycardia, are frequently present.

Ventricular tachycardia comprises a small fraction of the paroxysmal tachycardias of infancy, and is usually associated with serious pre-existing cardiac disease. It is most important to differentiate ventricular from supraventricular tachycardia, in management and in prognosis. With ventricular tachycardia, the heart rate is somewhat irregular and there is no response to vagal stimulation. The electrocardiogram shows a ventricular rate greater than the atrial rate, a widened QRS complex and occasional ventricular capture. Ventricular tachycardia is an ominous arrhythmia, best treated with quinidine.

Paroxysmal atrial flutter and paroxysmal atrial fibrillation rarely occur in infancy. They are usually associated with congenital heart disease or with active carditis.

Spontaneous Termination

Paroxysmal supraventricular tachycardia may occasionally terminate spontaneously. The first maneuver to be tried to revert supraventricular tachycardia is reflex stimulation of the vagus nerve, although this is less often successful than in the adult. Unilateral, never bilateral, carotid sinus pressure should be applied for 30 to 60 seconds, with continuous electrocardiographic monitoring. Breath holding, gagging or induction of vomiting may also be effective. Vagal stimulation by eyeball pressure is mentioned only to condemn it; in the baby who cannot report pain, retinal detachment is a significant hazard. Occasionally, placing the child in a head down position may augment the effect of vagal stimulation. It is most important that hypotension be corrected before attempting reversion of the arrhythmia, because arrhythmias are far more difficult to terminate in the presence of shock.

Drug of Choice

A digitalis glycoside is the drug of choice for termination of supraventricular tachycardia in infancy; 80 per cent of the tachycardias are successfully terminated by digitalis therapy within two days. The recommended dose of digoxin is 0.03 to 0.04 mg. per lb. of body weight. Half the dose should be administered initially, a quarter in four to six hours and the remaining quarter in eight to 12 hours. The daily maintenance dose of digoxin is one-tenth of the digitalizing dose, and therapy is best continued for two to four weeks after reversion of the tachycardia.

When digitalis therapy is unsuccessful, as may occur with congenital heart disease or Wolff-Parkin-

son-White syndrome, quinidine may be administered in a dosage of three mg. per lb. for each of four to five doses every two hours. Occasional successful reversion of supraventricular tachycardia has been reported with procaine amide, neostigmine and acetylcholine hydrochloride, although significant toxic effects may accompany therapy with these drugs.

Concomitant Therapy

Concomitant therapy should include oxygen administration as needed, antibiotics to treat infection, and morphine or barbiturate sedation to alleviate restlessness.

After a single episode of supraventricular tachycardia, long term cardiac therapy is usually not indicated to prevent a recurrence. With recurrent supraventricular tachycardia, digitalis or quinidine maintenance therapy may be given—digoxin 0.125 to 0.25 mg. daily or quinidine 60 to 200 mg. daily is the recommended dosage.

Favorable Prognosis

The prognosis is favorable after an attack of paroxysmal supraventricular tachycardia. The mortality rate from the initial acute episode is low, two to five per cent, with the higher figures referable to the younger age group and to patients with associated heart disease. Twenty-five per cent of supraventricular tachycardias never recur; the remaining 75 per cent of patients have one or more recurrences. With the onset of tachycardia in the first four months of life, in the age group where the etiology is usually unknown, the recurrence rate is 22 per cent. Supraventricular tachycardia occurring after four months of age has a much higher recurrence rate, 83 per cent, reflecting the greater incidence of underlying heart disease.

Summary

In summary paroxysmal tachycardias of infancy occur most frequently in the first four months of life. The infants are usually seriously ill and prone to develop congestive heart failure and cardiovascular collapse. The exact nature of the tachycardia should be determined by the electrocardiogram. Supraventricular tachycardia is the most common form; reversion should first be attempted by vagal stimulation; if unsuccessful, digitalization will usually restore regular sinus rhythm. The prognosis is favorable in the absence of associated heart disease.

Emory University School of Medicine

Prepared at the Request of the Committee on Professional Education of the Georgia Heart Association.



"THE RIGHT OF PRIVACY"

Lloyd T. Whitaker, *Atlanta*

THE "RIGHT OF PRIVACY" may be defined, broadly, as the right of an individual to be left alone. It encompasses, again broadly, the right of an individual to his physical solitude or seclusion, the right to remain out of publicity which violates the ordinary decencies, the right to remain out of false but not necessarily defaming positions in the public eye, and the right of the individual to prevent appropriation of some element of his personality for commercial use.

Importance in Medicine

This right is obviously of considerable importance to physicians and hospitals. The right of privacy concerns hospitals more frequently but may well involve the physician. Violation of the right of privacy constitutes a civil wrong in most states of the United States. Georgia, in 1905, was a leader among the states in according judicial recognition to the right of privacy.

The kind of liability which can arise from a violation of the right of privacy is illustrated by a 1930 decision of the Supreme Court of Georgia. There it was held that a hospital was liable for damages to the parents of a deceased infant who was born with his heart on the exterior of his body. The hospital had allowed photographs to be taken of the deceased child's body without permission and the photographs had been published in a newspaper. While this obviously is an extreme case, it illustrates clearly that hospitals do have a duty not to violate a patient's right of privacy and may be held liable when this duty is violated.

The right of privacy, however, is not unlimited and later Georgia decisions indicate a tendency to-

ward a narrowing of the right. In 1955, the Georgia Supreme Court said:

"[There is a] tendency of courts of other jurisdictions to hold that, where an incident is a matter of public interest, or the subject-matter of a public investigation, a publication in connection therewith can be a violation of no one's legal right of privacy. We concur with this view."

Again in 1957, the Supreme Court of Georgia plainly stated that:

"The right of privacy is not absolute, but is qualified by the rights of others. 'No individual can live in an ivory tower and at the same time participate in society and expect complete non-interference from other members of the public'."

This limitation on the right of privacy recognizes the public interest in "news." Thus, a hospital which conservatively recognizes the interest of newspapers in police and accident cases by releasing, even without the patient's consent, the name of the patient, whether the patient is married or single, the sex, age, occupation, and address of the patient will do no wrong to the patient. But a hospital which goes into the details of second-hand information about a criminal brawl or gives a dramatic presentation of the condition of the patient might well incur liability.

Circumstances Dictate

A patient admitted to a hospital on the recommendation of his own physician for normal treatment or operation is certainly not as much a matter of public interest as a patient admitted to the hospital under more dramatic circumstances. However, the custom (especially in smaller communities) of pub-

lishing a list of patients in the hospital with their ages, addresses, and occupations points out that there is undoubtedly a public interest in the mere fact of hospitalization. Once again, the hospital might incur liability if it went into too much detail as to diagnosis and prognosis.

The right of privacy probably arises in the physician's private practice in a different context. For example, suppose that a dermatologist attained an unusual result in the treatment of a skin disease. He would like to publish an article in the journal of his specialty society. The article would have more meaning if pictures of the patient were included in illustrating the condition before and after treatment. Any physician, under these circumstances, would recognize the necessity for obtaining the written consent of the patient to the publication of the pictures and the article.

Less Obvious Circumstances

The question of necessity of consent to publication of articles can be somewhat difficult in less obvious circumstances. The use of a patient as a statistic, where no individual identification of the patient would be possible, probably would not require the consent of the patient. But if the history of the pa-

tient is necessary to illustrate the point of the article to be published in a specialty journal, the problem becomes closer. Even if the name of the patient is not used, if persons acquainted with the patient could identify him from the history given, the patient's right of privacy might be invaded and his consent should be obtained.

Publication Distinction

Courts undoubtedly would recognize a distinction between the publication of an article for scientific purposes in a specialty journal distributed only to doctors, and publication in a newspaper of broad distribution. However, the right of privacy includes the right not to be the subject of pictures or discussion even in specialty journals of limited circulation.

The right of privacy of a patient is unquestionably a subject of importance to hospitals and physicians; both must operate without the benefit of clearly drawn guidelines in the area. However, the hospital and physician who proceed on the usual basis of first regarding the patient's welfare, exercising common sense and good taste, and always looking for the patient's consent, will not have any difficulty with liability for invasions of the right of privacy.

Suite 1220 C & S Bank Building

Prepared at the request of The Medical Association of Georgia. Mr. Whitaker is a member of the firm of Alston, Miller & Gaines, General Counsel of The Medical Association of Georgia.

EYE CARE FOUNDATION ANNOUNCES ESSAY AWARD

The National Medical Foundation for Eye Care announces the Third Annual Helmholtz Memorial Award for the author of the finest article or essay on eye care published in a newspaper or magazine of general circulation in the period August 31, 1962, to August 31, 1963.

Principles of Competition and Selection

- 1) An eligible article or essay may be submitted by the author or on his behalf, by the editor of the medium in which it was published, or by any other person, including any member of the Foundation. The author may be a non-physician or a physician.
- 2) An eligible article must have been published under the author's name in a newspaper or magazine of general distribution within the dates specified for this contest. It must be directed to the lay reader.
- 3) An eligible article may deal with any aspect of the care of the human eye, the prevention of

blindness, the preservation or restoration of eyesight, or with any aspect of the research, science or practice of ophthalmology. An eligible article may be not less than 500 nor more than 5,000 words in length.

- 4) The author of the winning article will be expected to cooperate with the Foundation in securing the privilege of reprint without fee to the copyright holder or the author.
- 5) Eligible entries must be submitted to the office of the Foundation not later than September 30, 1963. Address: National Medical Foundation for Eye Care, 250 West 57th Street, New York 19, New York.
- 6) Eligible entries will be judged and the award selection made by the Board of Trustees of the Foundation. The Board reserves the right to make no award, or to designate more than one awardee.
- 7) A suitable certificate will be inscribed and presented to the award-winning author, together with a cash award of \$250.00.



AMA STATEMENT OF PRINCIPLES ON MENTAL HEALTH

THE SUB-COMMITTEE ON MENTAL HEALTH of the Medical Association of Georgia herewith presents to all physicians and Medical Auxiliaries of our State, the first of a series of articles emphasizing the importance of the current mental health program of the American Medical Association.

Our first effort is to establish and maintain communication. Your sub-committee is comprised of one member from each congressional district who will be responsible for information reaching the county societies, auxiliaries and communities of his area, and in turn will relate local problems to us. As pointed out in the following article, each physician, irrespective of his specialty, has a two-fold duty—that of a physician, and that of an interested citizen.

It is hoped that the articles to follow will assist in crystallizing an effective and on-going mental health movement for Georgia.

Mental illness is America's most pressing and complex health problem. Tremendous strides have already been made in improving the care and treatment of the emotionally disturbed but much remains to be done. The mental health field is vast and includes a network of factors involving the life of the individual, the community and the nation. Any programs designed to combat mental illness and promote mental health must, by the nature of the problems to be solved, be both ambitious and comprehensive.

Important Stake

The American Medical Association recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources. The physician participates

in the mental health field on two levels—as a man of science and as a citizen. The physician has much to gain from a knowledge of modern psychiatric principles and techniques and much to contribute to the prevention, handling and management of emotional disturbances. Furthermore, as a natural community leader, he is in an excellent position to work for and guide effectively mental health programs.

For these reasons, the Council on Mental Health of the American Medical Association was charged with developing a realistic, positive program which would more fully integrate the physician into the nation's mental health efforts. The Council has drawn up such a program, placing special emphasis on how the AMA, through its constituent societies and departmental councils and committees, can make significant contributions in the field of mental health.

The Community

Many of the existing shortages and problems in mental health must be met at the community level. Adequate facilities must be readily available for treating individuals on both an inpatient and outpatient basis. These facilities extend beyond psychiatric units in local and state hospitals and include child guidance centers, vocational and family counseling services, low and variable cost adult psychiatric services, home care treatment, follow-up clinics and rehabilitation centers. Continuing, long-term programs must also be planned at the community level to meet the mental health needs of the child, the family, the aged, as well as the mentally retarded, the delinquent, the alcoholic, the narcotic addict, and the sociopath.

This is a broad order which obviously cannot be filled for some time. Its scope increases with the

From Proceedings of National Congress on Mental Illness and Health held October 4-6, 1962, Chicago, Illinois.

realization that facilities and programs must be staged by persons trained in both medical and non-medical disciplines. The AMA will work to alleviate current personnel shortages and also to encourage careers in mental health.

The AMA will also be more active in encouraging physicians to become leaders in community planning for mental health. The AMA's first National Congress for Mental Illness and Health, held October 4-6, 1962, was organized so that physicians and other interested parties could meet together to discuss and organize effective, regional programs. This Congress was part of a continuing effort to effectively channel physicians' participation into mental health activities.

Shortages in mental health personnel and facilities are related to a shortage of funds available for mental health needs. Few communities have the resources necessary for adequately developing and expanding their mental health services. For this reason, the AMA supports multiple source financing for community mental health services and recognizes the need for additional expenditures, at all levels, in this area.

Physician-Patient Relationship

The AMA has always stressed the importance of the physician-patient relationship in the practice of medicine. Modern psychiatry has made significant contributions in bringing about a deeper understanding of this concept and its importance in treating illness. Knowledge of interpersonal relationships and psychiatric techniques should be integrated into all phases of the physician's educational development.

The American Medical Association has a deep interest in fostering a general attitude, within the profession and among the lay public, more conducive to solving the many problems existing in the mental health field. The Council on Mental Health is encouraged to implement the programs necessary

to fully utilize the resources of the medical profession in the fight against mental illness.

Dr. Blasingame

After the Congress, Dr. F. J. L. Blasingame, American Medical Association Executive Vice-President, made the following important statement:

"The principal charge given to the AMA's National Congress on Mental Illness and Health was that the participants should, upon returning to their communities, assume the responsibility of seeing to it that the many ideas and suggestions garnered during the meeting are put to work. In short, that, in effect, they become missionaries to transport and transplant the spirit of the Congress.

Leadership

Since the Congress, I have heard from both medical and non-medical participants and all of their remarks indicate that there is a definite need for leadership in mental health by the medical profession and that this Congress indicated to them that the AMA is willing, eager and able to assume this role.

"I think it is essential that the AMA sponsor similar Congresses in the future focusing, at times, on specific topics and, when appropriate, coordinating a variety of mental health facets as we did at this Congress. Through these meetings, progress can be assessed and fresh stimuli applied to problem areas.

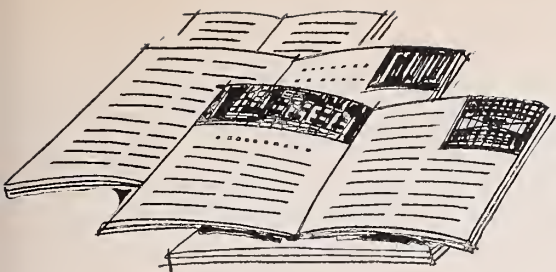
"Actions, not words, are what are needed now in the field of mental health. The AMA plans to keep its program moving in an attempt to supply the medical guidance and leadership so necessary to achieving meaningful mental health objectives. In fulfilling this goal, we solicit the active support and cooperation of the many professional and citizens' groups engaged in mental illness and health activities. The outcome of these important joint ventures will play a major role in improving mental health programs and facilities throughout the country."

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

MARKLE FOUNDATION SCHOLAR APPOINTED TO MEDICAL COLLEGE FACULTY

Dr. Arthur C. White, a Markle Foundation Scholar, has been appointed to the faculty of the Medical College of Georgia. Transfer of his support from the University of Louisville was announced only recently by the John and Mary R. Markle Foundation.

Dr. White is a graduate of Harvard Medical School. He interned and took his residency at Vanderbilt Hospital. His special interest is in infectious diseases, leading to his present work on the epidemiology of staphylococci and investigation of new antibiotics.



CURRENT CLINICAL CONCEPTS

Booth S-157; S-158; S-159 Esophageal Hiatus Hernia

J. Murray Beardsley, M.D.; Providence, R.I. Hospital.
Drs. John L. Sawyers, J. Lynwood Herrington, Jr. and
William H. Edwards. Nashville, Vanderbilt University
School of Medicine.

THESE BOOTHS had to do with a review of the current therapy for esophageal hiatus hernia. In essence these men and their pictorial and factual information were in concurrence. They agreed that patients with esophageal hiatus hernia, particularly those in which hyperacidity was a factor, should have preferentially a trans-abdominal repair of the hernia with a concurrent vagotomy and pyloroplasty. The results of these operations for the most part were good and only in rare instances was an antrectomy recommended. This was for the most part in those individuals with which there was concurrent duodenal ulcer disease associated with marked obstruction.

Abstracts from the American College of Surgeons Forty-Eighth Clinical Congress. Atlantic City, N.J. Oct. 15-19, 1962.

Booth S-127 Hood Needle Biopsy

Drs. Constantine Cope and Herman Bernhart. Memphis V.A. Hospital.

THESE DOCTORS demonstrated the use of a special needle which could be introduced into the pleural cavity or into the area of tissue from which a diagnosis was to be made. The obturator portion of the needle contained a small hook like protrusion and after the needle had been introduced the outside sheath was removed and the hook portion of the needle would grasp the tissue to be diagnosed and then in turn the outer sheath would be re-introduced and shear off the portion which had been caught by the hook. It was a most ingenious device and one that will probably be more rewarding than the standard Vim-Silverman needle.

Abstracts from the American College of Surgeons Forty-Eighth Clinical Congress. Atlantic City, N.J. Oct. 13-19, 1962.

Spontaneous Rupture of the Stomach

Archives of Surgery, Volume 86. Number 1. January, 1963.

Drs. Carl Davis, Jr., Richard Andresen, Osmund Akre and William McCarthy. Chicago, Ill.

THIS ARTICLE had to do with a most interesting case of a spontaneous rupture of the stomach with-

out previous vomiting. Emphasis was made on the early recognition of the spontaneous rupture of the stomach and prompt surgical intervention to reduce morbidity and to prevent death. The early roentgen examination of the abdomen should always be undertaken and the possibility of a ruptured stomach should be considered. These often occur in the upper aspect of the stomach in both the anterior and posterior positions.

Complications of Abdominal Aortic Surgery

Archives of Surgery. Volume 86. Number 1. January 1963.

Drs. Alfred W. Humphries, Jess R. Young, Victor G. deWolfe and Fay A. LeFevre. Cleveland.

SEVENTY CASES of postoperative aortoenteric fistula were reviewed by these doctors. They were derived from the English-language literature and their personal experiences have been summarized. This occurs when the intestine becomes adherent to the graft suture line at a point where bleeding takes place from the arterial side. This can be prevented by finding the healthiest aortic tissue available for suture and by doing a meticulous anastomosis. In addition, separation of the graft from the intestine by soft tissue, omentum, peritoneum and/or possibly interpositional foreign material should also be employed. Additional complications such as intestinal ischemia were listed. This may be treated by prompt recognition of the clinical picture of hypotension, persistent abdominal distention and diarrhea. Sigmoidoscopic examination proved most valuable and probably should be done routinely following abdominal aortic surgery. In addition, in a patient with potentially dangerous vascular lesions, the bowel should be prepared preoperatively by administration of antibiotics.

Some Experience with Retroperitoneal Lymph Node Dissection and Chemotherapy in the Management of Testis Neoplasms

Whitmore, Willet F. *Brit. J. of Urology*, 1962, 34:436.

THE SUCCESSFUL TREATMENT of metastatic malignant tumors of the testicle may well depend upon the combined use of chemotherapeutic agents such as the antitumour antibiotic actinomycin D, the anti-metabolite methotrexate and the alkylating agent chlorambucil combined with supervoltage irradiation.

THE ASSOCIATION



DEATHS

J. H. BOLAND, 55-year-old Atlantan, died February 9, 1963, in a private hospital.

A native of Atlanta, Dr. Boland was a graduate of the University of Georgia and Emory University Medical School, and received special training at the Hospital of Special Services in New York City, Yale University Medical School, and the University of Michigan.

He was a member of Trinity Methodist Church, the Piedmont Driving Club, the Capital City Club, the Nine O'Clock club and Chi Phi Fraternity.

He was also a member of the American Medical Association, Medical Association of Georgia, Fulton County Medical Society, American Academy of Orthopedic Surgeons, the American Board of Orthopedic Surgery, Industrial Medical Association, Southern Medical Association, Southeastern Surgical Congress and the Georgia Orthopedic Society.

He is survived by his widow, the former Laura Hill; a daughter, Laura Boland; a son, Joseph H. Boland, Jr.; his mother, Mrs. Frank K. Boland, Sr., and a brother, Dr. F. K. Boland, Jr., all of Atlanta.

EARLE E. MOSELEY, Donalsonville, died February 27, 1963, after a short illness in a New Orleans hospital.

Dr. Moseley owned and operated Moseley Hospital and Clinic in Donalsonville and was an active member of the Decatur-Seminole Medical Society, the Medical Association of Georgia, and the AMA. He was graduated from the Tulane Medical School and had practiced medicine in Donalsonville since 1937. He was a trustee of Friendship Methodist Church, a director of the Donalsonville Chamber of Commerce, and a member of the Lions Club.

Dr. Moseley is survived by his wife, Mrs. Agnes Hodges Moseley; one son, James Brown Moseley, a cadet in military school at Chattanooga, and a daughter, Miss Mary Alice Moseley of Donalsonville; two brothers; Arver Moseley of Jakin, and Elton Moseley of Maxia, Texas; and six sisters, Mrs. W. E. Clements, Arlington; Mrs. J. J. Foreman, Panama City, Florida; Miss Willie Moseley, Jakin; Mrs. I. E. Bivings, Jakin; Mrs. Earl Humber, Lumpkin, and Mrs. C. C. Foster of Donalsonville.

WILLIAM GROOVER SKIPPER, 43, Atlanta physician, died April 2, 1963.

Dr. Skipper attended Florida Southern and received his medical degree from Emory University School of Medicine. He was a member of the Rock Springs Presbyterian Church, the Medical Association of Georgia, and the AMA.

Dr. Skipper is survived by his wife, the former Myra White of Atlanta; four daughters, Misses Jane, Myra, Peggy, and Molly Skipper; two sons, William G. Skipper, Jr. and Roscoe W. Skipper, all of Atlanta; his

mother, Mrs. Roscoe N. Skipper; a sister, Miss Mary Skipper, and a brother, Roscoe N. Skipper, Jr., all of Lakeland, Fla.

SOCIETIES

BARTOW COUNTY MEDICAL SOCIETY held its March meeting in Cartersville. A discussion of the Kerr-Mills program was presided over by Dr. L. Ross Whatley. Dr. Whatley was assisted by Dr. Virginia Hamilton, Dr. Harvey Howell and Mr. Milton Krueger, of the Medical Association of Georgia.

DEKALB COUNTY MEDICAL SOCIETY in cooperation with the DeKalb-Decatur YMCA and the DeKalb Ministerial Association recently sponsored a series of classes in sex education for teenagers and parents. The classes were first initiated last spring. Classes met from 7:30-9:30 at the Midway Presbyterian Church and the Decatur First Methodist Church.

FIRST DISTRICT MEDICAL SOCIETY held its March 26 meeting in Statesboro. After a business meeting and social hour and banquet, Dr. J. K. Quattlebaum of Savannah introduced the speaker for the evening, J. G. Black of Beaufort, South Carolina. Installation of officers was held as the last order of business at the meeting.

THE GEORGIA MEDICAL SOCIETY held its regular meeting April 9, 1963, at Savannah. Dr. James A. Kemp, Director of Medical Education at Memorial Hospital of Chatham County, spoke on Postgraduate Medical Education.

GLYNN COUNTY MEDICAL SOCIETY met in March at Brunswick. Speaker for the program of the meeting was Dr. Torre, who spoke on amputees following the Korean conflict.

HALL COUNTY MEDICAL SOCIETY served as host to the NINTH DISTRICT MEDICAL SOCIETY at the April 17 meeting held in Gainesville. A program sponsored by the Georgia Academy of General Practice with assistance from Eli Lilly & Co. featured four doctors from New Orleans, Louisiana; Jacksonville, Florida; and Chapel Hill, N.C.

SECOND DISTRICT MEDICAL SOCIETY held its semi-annual meeting April 4, in Moultrie. Georgia doctors featured on the program, "Cancer of the Ovary," and "Cancer of the Cervix," were Dr. George A. Williams, Atlanta; Dr. Richard C. Elmer, Atlanta; and Dr. Hoke Wammock, LaGrange.

SOUTHWEST GEORGIA MEDICAL SOCIETY held their regular bi-monthly meeting in March at Blakely. Doctors' Day was highlighted with the Woman's Auxiliary presenting the program.

SPALDING COUNTY MEDICAL SOCIETY, Griffin, had as its April meeting speaker Dr. Carl Hartrampf of

Atlanta, who presented a program on, "Acute Hand Injuries."

TENTH DISTRICT MEDICAL SOCIETY held its winter meeting March 21, 1963, in Augusta. A scientific meeting was held featuring guest speakers, Dr. Charles Freeman, Jr., Dr. Frederick Zuspan, Dr. Louis Battey, and Dr. William Laupus, all of Augusta.

PERSONALS

First District

LAWRENCE LEE, JR., Savannah, was elected March 19, 1963, as the President of the Savannah Rotary Club. He will take office in July.

Second District

Speaking against socialized medicine at a recent Thomasville-Boston-Monticello joint Kiwanis Club meeting held in Boston was GEORGE R. DILLINGER, of Thomasville.

Third District

Husband and wife physicians, CALVIN and AGATHA THRASH have recently moved into new offices at the corner of Warm Springs Road and Calvin Street in Columbus.

C. M. JOHNSON, Eastman, has recently opened and will operate the new Middle Georgia Medical Nursing Home recently opened on the outskirts of that city.

Fourth District

Two Griffin doctors recently were guest speakers at local civic clubs. JAMES SKINNER presented a program to the Griffin Pilot Club, and J. W. KELLY spoke to the Griffin D.A.R. Chapter. Both program topics concerned cancer.

Griffin Internist, JACK LANDHAM, was recently elected to serve as President of the Griffin Rotary Club for the year 1963.

"Physical Maturation of Teenagers," was the topic of a talk given recently by A. S. FITZHUGH, Griffin, to the Spalding County Junior High P.T.A.

At the March meeting of the Orrs Grammar School P.T.A., JAMES A. DUNNAWAY, Griffin, presented a program entitled, "Behavior Problems in Elementary School Age Children."

Speaking at the recent meeting of the Tri-H-Y Club at Griffin High School on the subject of "Physical Effects of Tobacco and Alcohol," was GRADY DUKE of Griffin.

Fifth District

J. D. MARTIN, Atlanta, has recently been elected President of the Southeastern Surgical Congress.

During February 24 through March 2, 1963, JOHN D. THOMPSON, Atlanta, was visiting professor at the Orange Memorial Hospital in Orlando, Florida.

Guest speaker at the March 4 meeting of the New Orleans Graduate Medical Assembly was TED F. LEIGH, Atlanta Radiologist.

SAM WILKINS, Atlanta, spoke to the Atlanta Medical Association February 21, 1963, on, "Management of a Lump in the Breast."

The Atlanta YMCA recently sponsored a series of symposiums on the relationship of exercise and health, and emotional tension and health. The series, part of the Spring Quarter Adult Education program, was co-sponsored by Fulton County Medical Society. Following are the speakers who comprised the program: DAN BURGESS, "Exercise and Your Heart;" ROBERT L. WHIPPLE, "Tension and How to Control It;" WILLIAM PAULLIN, JR., "Exercise and Obesity;" FRED ALLMAND, "Exercise, Its Use and Misuse;" RICHARD E. FELDER, "Living With Your Emotions;" and CLARENCE W. MILLS, "Respiratory Diseases."

Sixth District

CARL L. ANDERSON, 86, Bibb County's oldest physician, has recently retired after practicing medicine for 53 years in Macon.

Seventh District

WILLIAM C. PORCH has recently moved to Douglasville to practice medicine. He will share offices with C. V. VANSANT, JR. Before coming to Douglasville, Dr. Porch had a practice in Chatsworth.

O. A. SIMS, Dalton, has announced the closing of his medical offices due to failing health.

Participating in a March postgraduate course at the Medical College of Georgia were three Dalton physicians. DAVID A. WELLS, TRUMAN W. WHITFIELD, and LOYD C. YEARGIN.

DON THOMAS, a graduate of the Medical College of Georgia, has recently opened his new offices on the Cleveland Highway at Dalton.

Eighth District

No news submitted.

Ninth District

W. W. PUETT, Norcross, is recovering in the hospital from a recent operation.

Attending a medical review at the Mayo Clinic in Rochester, Minnesota, during the month of March were JOE L. GRIFFETH, Commerce, and A. D. MUSE, Jefferson. After completion of the Mayo meetings, they flew to Indianapolis, Indiana, where they toured the Eli Lilly Pharmaceutical Company.

Gainesville physician, HENRY JENNINGS, served as a delegate at the March national convention of the American Society of Internal Medicine held in Denver.

R. A. BURNS of Blue Ridge has recently been named Chief of Staff at the Copper Basin General Hospital.

Tenth District

A. G. LEROY, Thomson, attended the March postgraduate courses held at the Medical College of Georgia in Augusta.

PAUL E. KELLER, Athens, has assumed the duties of Physician-in-Charge of the Employee's Health Section of the Occupational Health Service, Georgia Department of Public Health, filling the vacancy left by H. F. LARAMORE, Atlanta.

"Georgia's Need for Health and Medical Care," was the topic of a talk given recently to the Richmond County Medical Assistants by PRESTON D. ELLINGTON, Augusta.

THE ASSOCIATION / Continued

Appearing on the program of the May meeting of the American Thoracic Society held in Denver were THOMAS J. YEH, DAVID P. HALL, and ROBERT G. ELLISON, all of Augusta. The paper they presented was entitled, "Empyema Thoracis, A Review of 110 Cases."

Two Augusta doctors were sponsors of a prize-winning

MEDICAL EDUCATION BOARD MEETING

THE MEETING OF THE Medical Association of Georgia Medical Education Board was called to order by Chairman T. A. Sappington at 2:15 P.M., on February 24, 1963, at the MAG Headquarters Office Building, Atlanta, Georgia.

Members of the Board present included: T. A. Sappington, Thomaston, Chairman; Walter Bloom, Marietta; Braswell Collins, Macon; and W. H. M. Weaver, Macon. Also present was Mr. Milton Krueger of the Headquarters Office Staff.

Dr. Sappington reported on the Medical School Subcommittee activity, and he stated that because of other matters and for a re-evaluation, the annual course "Art of the Practice of Medicine" had not been scheduled for January through March of 1963. He discussed the fine reception for this course in the past five years at the Medical College of Georgia and the difficulty in scheduling such a course at Emory University School of Medicine. He assured the Board that the course would be scheduled for 1964.

Dr. Walter Bloom reported on the activity of the Medical Education Subcommittee, and reported on attending the AMA Congress on Medical Education and Licensure held in Chicago in February.

Dr. Bloom outlined a program of medical recruitment, describing the Oklahoma brochure, the AMA Medical Career Kit, the AMA movie, "I Am A Doctor," and the AAGP Project MORE. Dr. Bloom cited these tools for use in a medical recruitment project, and it was recommended that Dr. Bloom rough draft a plan and a brochure for M.D. recruitment in Georgia and include this plan in his report to the MAG House of Delegates which will also be incorporated in Medical Education Board Chairman T. A. Sappington's report.

Dr. Bloom then also outlined a proposed Georgia Conference on Medical Education to be held in the State of Georgia on a statewide basis. The Board recommended that Dr. Bloom propose a plan, program and other details of such a meeting and work with Board Chairman Sappington in this connection so that the meeting may be convened late in 1963.

Dr. Bloom also discussed for some future date the Association co-sponsorship with community hospitals or medical societies of scientific programs. It was the recommendation of the Board that this project be held in abeyance at this time but be given full consideration in the near future.

Dr. Braswell Collins reported on activity of the AMA-ERF Subcommittee which replaces the AMEF Committee.

After due discussion of medical education matters in general, the meeting was adjourned at 3:45 P.M.

MINUTES OF MAG RURAL HEALTH COMMITTEE MEETING

THE MEDICAL ASSOCIATION of Georgia Sub-Committee on Rural Health met on March 17, 1963, at 1:30 P.M. in the MAG Headquarters Office Building, Atlanta, Georgia.

Members of the Committee present included Thomas Lumsden, M.D., Clarkesville, Chairman and R. D. Walter, M.D., Calhoun.

After a review of the past activity of the MAG Rural Health Sub-Committee, it was emphasized that tetanus and smallpox immunization is a project worthy of prime consideration by the Committee. Plans to implement this project over the state were to be determined at the next meeting of the Committee.

It was also emphasized that farm and home safety was another project for consideration by the Committee. Dr. Lumsden stated

scientific exhibit "Retroperitoneal—Retrofascial Space Infections," displayed at the annual meeting of the Southeastern Surgical Congress at Miami Beach in March. The two physicians are MARTIN RHODE, Associate Chief of Staff for Research, and WILLIAM D. JENNINGS, JR., Chief of Surgery, both of the Veterans Administration Hospital in Augusta. Drs. Rhode and Jennings also are members of the clinical faculty at the Medical College of Georgia.

that he would be attending the AMA National Rural Health Meeting on Farm and Home Safety and that he would have material to present to the Committee upon his return from this meeting.

Another project to be undertaken by the Committee was meeting with rural groups such as the Farm Bureau, the Agricultural Extension Service, etc. to request them to help ascertain other high priority projects in the field of health care of rural people. Chairman Lumsden suggested that a meeting with the Farm Bureau President be convened in the near future and also that he would set up a meeting with the Agricultural Extension Service personnel at the University of Georgia School of Agriculture, Athens, Georgia.

Members of the Committee were asked to think about additional members being appointed to the Committee so that each of the ten districts in Georgia could be represented at Committee meetings. It was agreed that the full Committee with the new appointees should meet in the latter part of May.

There being no further business, the meeting was adjourned at 3:00 P.M.

EXECUTIVE COMMITTEE OF COUNCIL MEETING

THE EXECUTIVE COMMITTEE of Council meeting was called to order at 11:05 A.M. at the Center for Continuing Education, Athens, Georgia, by the Chairman, President Thomas W. Goodwin.

The members in attendance were: Thomas W. Goodwin, Augusta; George R. Dillinger, Thomasville; George H. Alexander, Forsyth; John T. Mauldin, Atlanta; Lee H. Battle, Rome; Fred H. Simonton, Chickamauga; and J. G. McDaniel, Atlanta. Staff members present were: Mr. Milton D. Krueger, Mr. James M. Moffett and Mrs. Catherine Wooten.

Reading of Minutes

Mr. Krueger read the minutes of the February 17, 1963, Executive Committee meeting. On motion duly made and seconded the minutes were approved as read.

MAG Subcommittee Appointments

The following appointments to MAG subcommittees were made:

(a) Blood Banks: J. W. Iseman, Atlanta, Ex-officio; S. C. Rutland, Atlanta, member.

(b) Maternal and Infant Welfare: Morris Brackett, Atlanta, Ex-officio.

(c) Mental Health: W. D. Stribling, Gainesville.

On motion duly made and seconded these appointments were approved as presented.

Civil Suit Settlement

President Goodwin announced that the civil suit had been dismissed.

Blood Banks Subcommittee Report

Mr. Moffett stated that at the February meeting of this subcommittee the following items were discussed and action taken: *Minimum Standards for Blood Banks*: These standards are being worked on by Dr. Walter Sheppard and Dr. J. W. Iseman.

Hospital Transfusion Committees

Chairman Norris requested that a "memorandum to all hos-

pitals in Georgia be mailed stating that the Subcommittee on Blood Banks, Medical Association of Georgia, wishes to recommend to and urge all hospitals in the state who receive and administer blood transfusions to appoint a Transfusion Committee on their staffs, composed of three persons, preferably a surgeon, an internist and a member of the laboratory. This committee would cooperate with the blood bank in every respect in order to enhance its safety and performance, and particularly to investigate every reaction occurring after blood has been given to a patient, reporting same to the subcommittee or the American Red Cross Blood Bank, Atlanta."

State Health Department of Blood Banking

It was voted by the Subcommittee on Blood Banks that "the Health Officer, Department of Health, State of Georgia, be requested to proceed to establish in the department, a division entitled: 'State Health Department of Blood Banking,' this unit to be under the direction of either a Pathologist, Clinical Pathologist, Hematologist or a licensed doctor who is recognized as a person capable of placing the division into proper perspective and development; whose other duties as the Director, shall be to investigate, inspect, and cooperate with state located hospitals or clinics whose staff administers blood to patients, or who may desire to have them do so at a future date; to certify same, and to draw plans for the proper storage of blood and its therapeutic constituents which may be needed in emergency; to further determine the operative fitness of hospitals having blood banks; including technical efficiency, to the extent that the public and the patients shall be protected; to cooperate with the American Red Cross and the American Association of Blood Banks; that legal steps to the establishment of this department be duly presented to the next available Legislature, in order that lawful status may be enacted to execute and promote the intent and purpose of this Resolution."

This report was received for information, as it will be submitted to the House of Delegates. It was suggested that a member of the Executive Committee attend the Reference Committee assigned this report to make known the views of the Executive Committee.

Headquarters Office Report

Mr. Krueger reported on: (1) Proposed visitation plan to county medical societies; (2) AMA Conference on National Legislation, April 20-21, 1963: Dr. Dillinger, Dr. Mauldin and Mr. Moffett to attend; (3) AMA meeting, June 16-20, 1963, Atlantic City: President, President-Elect, Secretary, AMA Delegates, and Executive Secretary will attend and hotel reservation cards were distributed.

Unfinished Business

(1) Pension Plan for Employees: Dr. McDaniel discussed various plans. After discussion he was instructed to obtain further information and report to the Executive Committee at the April meeting, and to inform Council that this was being investigated.

(2) Nursing Home Accreditation: Dr. Mauldin stated that the nursing homes were not very interested in an accreditation program probably due to their misunderstanding the position of the MAG in relation to the accreditation procedure. Received for information.

New Business

(1) Crawford W. Long Medical Society Problem: President Goodwin read a letter from this county medical society regarding physicians' tax deduction allowance. It was decided that Dr. Goodwin should discuss this with the Councilor, Dr. Hubert, and the MAG Attorney.

(2) District Medical Societies: President Goodwin stated that some of the district medical societies were not functioning properly and suggested that it be discussed at the June Council meeting. The inactive county medical societies should be discussed also at the June Council meeting.

(3) AMA Letter on National Blue Shield: Mr. Krueger read a letter from Mr. Stetler of the AMA Legal Division, asking MAG to give AMA an estimate of the situation in Georgia concerning the National Blue Shield proposal. It was recommended that the 1962 MAG House of Delegates action on the National Blue Shield Senior Citizens Program be quoted to Mr. Stetler in the reply.

(4) Southeast Georgia Medical Society: Dr. Mauldin read a letter from the President of the Southeast Georgia Medical Society regarding the question of endorsement of the "Family

Planning Services" program of the County Health Department of District No. 10. It was recommended that a letter over the President's signature be written the Southeast Georgia Medical Society that it was the opinion of the Executive Committee that this is within their own province of decision.

(5) Breakfast Meeting with Governor Sanders: President Goodwin was asked to contact the Governor regarding a date for a breakfast meeting to discuss matters of importance to MAG. It was suggested that this might be arranged for the April Executive Committee meeting. If this cannot be arranged, a telephone conference meeting might be sufficient if there are insufficient items for the agenda to warrant a meeting at MAG.

There being no further business the meeting was adjourned at 1:00 P.M.

**MEDICAL ASSOCIATION OF GEORGIA
COUNCIL MEETING**

THE QUARTERLY MEETING of the Council of the Medical Association of Georgia was called to order at 2:10 P.M., on March 23, 1963, at the Center for Continuing Education, Athens, Georgia, by the Chairman George H. Alexander.

Members attending were: George H. Alexander, Forsyth; John S. Atwater, Atlanta; J. W. Yeomans, Jesup; Charles T. Cowart, LaGrange; William Simmons, Sylvania; Charles Bohler, Brooklet; Frank Wilson, Leslie; P. T. Scoggins, Commerce; M. A. Hubert, Athens; William Rawlings, Sandersville; Walker L. Curtis, College Park; J. L. Mulherin, Augusta; W. Frank McKemie, Albany; Lee H. Battle, Rome; Joseph B. Mercer, Brunswick; Thomas W. Goodwin, Augusta; J. G. McDaniel, Atlanta; George R. Dillinger, Thomasville; John T. Mauldin, Atlanta; Walter Brown, Savannah; Fred H. Simonton, Chickamauga; Ralph N. Johnson, Rome; Harry D. Pinson, Augusta; Addison Simpson, Washington; Charles S. Jones, Atlanta; Henry H. Tift, Macon; Virgil Williams, Griffin; Luther H. Wolff, Columbus; Eustace A. Allen, Atlanta; Edgar Woody, Jr., Atlanta; and J. Frank Walker, Atlanta. The MAG Attorney, Mr. John Moore, was present, as well as MAG Staff members Mr. Milton D. Krueger, Mr. James M. Moffett and Mrs. Catherine Wooten. Mr. Loran Smith, Conference Coordinator, Center for Continuing Education, University of Georgia, Athens, welcomed the members of Council to Athens.

Request for Approval for Study on Mobility of Physicians

Mr. Louie A. Brown, University of Georgia graduate student, explained to Council the purpose of his study and asked for MAG endorsement. Mr. Brown was excused in order that Council might discuss his request. After discussion, on motion duly made and seconded, it was voted that the Association would write a letter to be included with the individual questionnaires, and that this letter should state that the Medical Association of Georgia endorses this study provided it is understood that it does not participate in, and is not responsible for, the formulation of the questionnaire or the conclusions derived from answers given. On further motion duly made and seconded it was voted to request Mr. Brown to submit a copy of his final conclusions to the Medical Association of Georgia.

Reading of Minutes

Mr. Krueger reviewed the minutes of the December, January and February meetings of Executive Committee and the December Council meeting. On motion duly made and seconded it was voted to approve the minutes as read.

Auditor's and Treasurer's Report

Dr. Atwater presented the Auditor's Report and the Treasurer's Report. On motion duly made and seconded these reports were approved as read.

Certificates of Appreciation

Mr. Krueger read the proposed list of recipients of Certificates of Appreciation, which had been suggested at the February Executive Committee meeting for Council approval: President, Secretary (if term of office expires and he does not wish to run again); Chairman of Council (if not re-elected); First Vice President; Thomas A. Hendricks, AMA, for his service to the Medical Association of Georgia, American Medical Association, and the profession during the years; Joseph B. Stetler, AMA, for his service to the Medical Association, the American Medical Association, and the profession during the years; Helen W. Bellhouse, for her service as Secretary of the Maternal and

THE ASSOCIATION / Continued

Infant Welfare Sub-Committee for many years; August S. Yochem, for his service as Chairman of the Weekly Health Committee for many years; and Eustace A. Allen, for his service as Vice President of the American Medical Association, 1961-62, which position brought recognition and honor to the Medical Association of Georgia. On motion (Mercer-Brown) it was voted that there be a Certificate of Service created for a man who is elected to an office; and that the Certificate of Appreciation be given to those who the Council wishes to recognize for work done for MAG. This action is to become effective next year. On amended motion (Atwater-Brown) it was voted that the above motion be referred to the Executive Committee for decision. On motion duly made and seconded the above named as suggested recipients of a Certificate of Appreciation were approved to receive a certificate.

Georgia Hospital-Medical Council

Dr. Mauldin stated that \$500.00 had been contributed by the Georgia Chapter, American College of Surgeons, toward the cost of printing a revised manual for the Georgia Hospital-Medical Council. He then asked Dr. Cowart to give a progress report of the Council's work. Dr. Mauldin then made a request for Council's approval for \$500.00 to be contributed by MAG to help defray the cost of printing this manual. On motion (Mauldin-Bohler) it was voted to approve the \$500.00 request with the stipulation that the money be taken from the Contingent Fund. Dr. Mauldin then discussed the nursing home accreditation program, in which the nursing homes did not appear to be interested. Council voted commendation to Dr. Cowart for the activities of the Georgia Hospital-Medical Council.

AMA Medicolegal Symposium

Dr. Charles S. Jones reported on the AMA Medicolegal Symposium held in Miami Beach, March 8-9, 1963. He suggested that thought be given to allotting time for a special session at the Annual Session to discuss and educate the members regarding good patient-physician relationship in order to avoid malpractice suits.

Relative Value Study Report

Dr. Harry Pinson reported that in preparing a Relative Value fee schedule a figure had been obtained from statisticians for carrying out this study of \$1,551.00. There is \$700.00 already set aside for this purpose but an additional \$800.00 would be required. A motion (Mauldin-Wolff) was made that this should be tabled until such time as there is an actual need for such a study. However, after a dissenting vote on this motion a new motion was made. On motion (Goodwin-Mercer) it was voted to approve the addition of \$800.00 for the study from the Contingent Fund, and to proceed with the study.

Civil Suit Settlement

President Goodwin reported that the civil suit had been dismissed.

Report of Constitution & Bylaws Board

Mr. Krueger read the report of the Constitution and Bylaws Board, which included (1) the matter of the First Vice President becoming a voting member of the Executive Committee of Council; (2) the Medical Defense Committee; (3) and additional Councilors in Districts where there are already two Councilors. On motion duly made and seconded it was voted that the item (3) be tabled at the present time and considered at the June meeting of Council; the other two items having already been acted upon.

Resolutions on Podiatry

Dr. Mauldin read the action taken on the Columbus Blue Shield Resolution on Podiatrists, which was presented to the December Council meeting, and referred to the Executive Committee for advisement and report back to Council. He stated that after discussion at the January Executive Committee meeting, it was decided to take no action on the resolution and to receive it for information. He also read the Walton County Medical Society Resolution on Podiatry, which, at the February meeting of the Executive Committee, had been voted to refer to Council. Discussion began on this subject but Chairman Alexander called for recess and stated that the discussion would

be continued on Sunday, March 24.

The Chairman then recessed this portion of the Council meeting at 5:25 P.M.

* * * * *

The March meeting of the Council was reconvened at 8:35 A.M. on March 24.

Legislative Report

Dr. Walker reported on the AMA Legislative meeting in Washington, March 23. Mr. Moffett gave a report on the state legislative picture, mentioning the: Podiatry Bill, the Recodification of Public Health Laws, Family Responsibility Bill, Composition of Board of Medical Examiners change, Seat Belts Bill, Dental Scholarships, One Year Internship Bill, Workmen's Compensation Bill, and Confidential Medical Information Bill. On motion duly made and seconded it was voted to approve this report as a whole and commend Mr. Moffett for his work during the General Assembly.

Resolutions on Podiatry

Discussion was resumed on this subject by Dr. Wolff who read a substitute Resolution.

After much discussion on motion (Wolff-Mercer) it was voted to approve this Resolution in principle, to refer it to Executive Committee and the MAG Attorney for any changes in the wording that might be necessary, and referral back to Council at the May meeting for submission to the House of Delegates as a Supplemental Report of Council.

County Medical Society Membership Problems

Dr. McKemie and Dr. Wilson stated that they had been assured the inquiry of R. E. Jennings, M.D., of Arlington, who had requested a ruling on transfer of membership to a more active county medical society, had been solved. The society, of which he was a member, the Randolph-Terrell County Society, is now reactivated and Dr. Sills, the Secretary, should be informed that according to the MAG Constitution and Bylaws, the members of his society could not transfer their membership to another society.

Extension of Professional Liability Insurance

Mr. Krueger stated that Dr. Wolff, at a previous Council meeting, had asked if the St. Paul Insurance Companies would cover an individual's acts or omissions while serving as an officer, committee or board member of any organized medical group. He then read a letter from the St. Paul Companies stating that the St. Paul Fire and Marine Insurance Company has always recognized claims of this nature under the policy carried by the MAG members.

Occupational Health Board Report Re Revised Workmen's Compensation Fee Schedule

Dr. McDaniel gave a report on the revised Workmen's Compensation Fee Schedule and on motion duly made and seconded it was voted to approve the revised fee schedule.

Special Projects Items

Mr. Krueger presented (2) the proposal made by the Executive Committee of Specialty Society representation in the MAG House of Delegates. After discussion, on motion (Mercer-Bohler) it was voted to refer this item to the Constitution and Bylaws Board for recommendation to Council; (b) Headquarters Office Reorganization was another proposal by the Executive Committee due to the need for additional staff assistance and the possible employment of an additional secretarial employee. Executive Committee recommended the promotion of Mrs. Catherine Wooten to an Assistant Executive Secretary effective April 1, 1963. The additional secretary will be employed at a future date when warranted. On motion duly made and seconded it was voted to promote Mrs. Wooten to Assistant Executive Secretary and to consider the employment of another secretary at a future date.

Headquarters Office Report

Mr. Krueger informed Council of the recent purchase of office equipment; discussed employment of additional personnel for Medicare and OAA; and announced several items of interest regarding the forthcoming MAG Annual Session at Jekyll Island. Mr. Moffett asked permission to print certain information on the back cover of the Delegate's Handbook. On motion duly made and seconded it was voted to approve this request.

Old Business

(1) President Goodwin stated that he thought it wise for Council to consider the advisability of a study of a redistricting of the state with regard to District Medical Societies, and also to consider the consolidation of some of the smaller county medical societies to strengthen them. He recommended that this report be submitted to the 1964 House of Delegates. After discussion, on motion duly made and seconded it was voted to approve Dr. Goodwin's recommendation.

(2) Treasurer Atwater asked how the AMA Alternate Delegates' expenses were to be paid. He was informed that transportation only was to be paid for the alternate delegates, and full expenses for the delegates. This was a previous Council action needing clarification.

(3) Pension Plans: Dr. McDaniel gave a progress report on pension plans for MAG employees, which had been deferred from a previous Council meeting. He was instructed to investigate several plans with the assistance of the Finance Committee, and report back to Council.

(4) Woman's Auxiliary: Mrs. Waldemayer's letter of appreciation for the allotment of the Auxiliary budgetary request for 1963 was read.

(5) Intensive Care Center at VA Hospital: Letter read. Received for information.

(6) Rural Health Subcommittee: A request for funds for this subcommittee was made so that the Chairman might attend an AMA meeting in Chicago. This subcommittee had no chairman at the time budget requests were made and the subcommittee was not allotted monies for operation in 1963. On motion (Mauldin-Simonton) it was voted that \$200.00 be taken from the Contingent Fund to be set aside for the Rural Health Subcommittee.

(7) Dr. Williams discussed ways and means of improving relations between the medical educators and the practicing phy-

sicians in Georgia. After much discussion he made a motion to refer this matter to the Medical Education Board to devise ways of improving relations between the medical educators and the practicing physicians in Georgia. This was seconded by Dr. Simonton. Chairman Alexander called for a vote by a show of hands and the motion was defeated by a vote of 8 for and 11 against.

(8) Dr. Yeomans asked Council's opinion regarding relations between pathologists, radiologists, anesthesiologists and hospital authorities regarding contractual arrangements. After lengthy discussion on a particular case, on motion (Goodwin-Simonton) it was voted that Dr. Walker, Dr. Mauldin and Mr. John Moore draft a letter to the Ware County Hospital Authority which would delineate the legal and ethical aspects of the problem in support of the present arrangement between the hospital and the radiologists, and if further action is necessary the problem can be discussed at the May Council meeting.

New Business

(1) Florida Medical Association Fraternal Delegates: President Goodwin to appoint these delegates.

(2) Medical Association of Alabama Fraternal Delegates: President Goodwin to appoint these delegates.

(3) GaMPAC Breakfast at Jekyll: Dr. Mercer asked for good attendance.

(4) Date and Site of May Council Meeting: May 4, 6:00 P.M., Buccaneer Motel, Jekyll Island.

(5) Date and Site of June Council Meeting: June 8-9, Callaway Gardens, Pine Mountain.

(6) A rising vote of thanks was given Dr. and Mrs. Hubert, Dr. and Mrs. Andrews and Dr. and Mrs. Simpson for their hospitality at this March Council meeting.

There being no further business the meeting was adjourned at 11:10 A.M.

EMORY NAMES NEW ASSOCIATE PATHOLOGY PROFESSOR

Dr. Louis Brahen of Yale has been named associate professor of pathology at Emory University's medical school.

Dr. Brahen will head the clinical pathology laboratory at Grady Memorial Hospital, further strengthening clinical pathology. A native of Philadelphia, Dr. Brahen received his A.B. at Temple, B.M.E. at North Carolina State, M.S. at the University of Pennsylvania and M.D. at Jefferson Medical College.

Dr. Louis G. Ortega has been named associate professor of pathology at Emory. He is now chief of the cytochemistry section and associate professor of pathology at Sloan-Kettering division of Cornell University Medical College. A native of New York, he received his M.D. degree at New York Medical College.

Dr. Harold S. Ramos, now chief of the Division of Medicine, U. S. Air Force Hospital, Keesler Field, has been appointed assistant professor of medicine. He will be director of medical education at Crawford Long Hospital. He is a native of Atlanta with an A.B. degree from Johns Hopkins and an M.D. from the Medical College of Georgia.

Dr. Robert A. Farrell will become associate in pathology. A native of Albemarle, N. C., he received his M.D. degree at the University of North Carolina School of Medicine. All appointments are as of July 1.

RESEARCH FORUM SCHEDULED AT AMA ANNUAL MEETING

The popular Multiple Discipline Research Forum will be held for the third year at the 112th annual meeting of the American Medical Association June 16-20 at Atlantic City.

More than 200 of the nation's top scientists, representing a cross section of nearly every medical specialty, will present new and original papers on three days of the meeting, June 18-20.

Physicians and medical scientists who have carried out original investigation of fundamental problems in medicine and medical practice were invited to submit abstracts of their work to the Forum Committee. Chairman is Edwin H. Ellison, M.D., professor and chairman of the Department of Surgery, Marquette University Medical School, Milwaukee.

The research forum program represents an avenue by which physicians can keep abreast of general scientific progress in medicine and thereby bring to their patients the best that medicine has to offer, Dr. Ellison said.

The program takes into account the fact that many advances in medical research today come from basic science and clinical laboratories where the newest and most complex techniques of chemistry, physics and biology are applied to studies of disease, he said.

"To remain alert and effective throughout their professional careers," he said, "physicians are well aware that they must now possess a much broader knowledge of the pre-clinical sciences than ever before."



vacancy

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*Staff in one mental hospital recently tried an experiment with 65 patients who had been confined for an average of 13 years. They practiced the best treatment methods now known and, within six months to a year, 37 of these patients were well enough to be discharged. Only eight of the discharged patients failed to hold the gains they had made for at least a year after they left the hospital."**

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*U.S. Department of Health, Education and Welfare, Public Health Service Publication No. 813.

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JOURNAL
OF THE MEDICAL
ASSOCIATION

JUNE / 1963

Georgia

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109th MAG
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**JOURNAL
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Contents

The Annual Session

OFFICIAL PROCEEDINGS, 109TH ANNUAL SESSION
OF THE MEDICAL ASSOCIATION OF GEORGIA,
MAY 5-8, 1963, JEKYLL ISLAND, GEORGIA

FIRST SESSION, HOUSE OF DELEGATES
SUNDAY, MAY 5, 1963 244

SECOND SESSION, HOUSE OF DELEGATES
WEDNESDAY, MAY 8, 1963 248

FIRST GENERAL BUSINESS SESSION
SUNDAY, MAY 5, 1963 288

SECOND GENERAL BUSINESS SESSION
MONDAY, MAY 6, 1963 289

THIRD GENERAL BUSINESS SESSION
WEDNESDAY, MAY 8, 1963 290

PICTORIAL GLIMPSES OF THE 109TH ANNUAL SESSION . . 286

Editorials

MEASLES IMMUNIZATION 293

BETWEEN A ROCK AND A HARD PLACE 294

Features

How Well Are We Telling
Our Story? 299
President's Letter 295
Cancer Page 296
Heart Page 298
Mental Health Page 300
Physician's Bookshelf 302
Abstracts 304

The Association

Deaths 306
Societies 306
Personals 306
Executive Committee of Council Meeting, April 15 . . . 307
Advertising Index 42A

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Special Article

REPORT FOR THE FUTURE

GEORGE R. DILLINGER, M.D., *Thomasville*
President of the Medical Association of Georgia

MR. PRESIDENT, GENTLEMEN: You have honored me by making me your President for the coming year. We will endeavor to carry out the mandates of your House of Delegates to the best of our ability. We know that we can depend on the Past President, our illustrious predecessor; the members of Council and the Executive Committee. We must also pay tribute to our excellent Headquarters Staff, for without them we could not function with the present efficiency and dispatch.

MAG Organization

The organization of our association has improved remarkably in the past decade. There have been several steps in building the present structure. About twelve years ago the Constitution and Bylaws were completely revised and brought up to date.

The size of Council was increased and a more equitable system of representation devised to give the more populous medical centers increased representation.

The last major change in our organization was to a Board of Commission Organization, regrouping our committees for more efficient activity.

It is the feeling of your Executive Committee that among the big problems facing organized medicine is the increasing separation and lack of communication between the various groups that make up our

profession. The existing gulf between the medical educators, the research groups, public health, military, and the practicing physicians, seems to be constantly widening. The proposal that the facilities of the medical schools, the public health organizations and other similar groups be given direct representation in our House of Delegates will, we believe, help to increase the understanding and communication between the various groups. The Medical Association of Georgia must constantly undergo change and improvement in its organization or it will stagnate and retrogress.

House of Delegates of AMA

Gentlemen, one of the problems that should be corrected is our representation in the American Medical Association. Georgia is entitled to one Delegate and one Alternate Delegate for each 500 AMA members. At the present time we are approximately 75 members short of having four Delegates.

As of December 31, 1962, there were 2,646 active members, 353 active dues exempt members, 51 service members, and 25 associate members — making a total of 3,075 members of the MAG.

In 1962 there were 559 Medical Association of Georgia members selling medicine short. They are denying themselves representation in the House of Delegates of the American Medical Association.

Where are these men located who sell medicine short? 289 are from our five most populous counties and cities — Fulton, Richmond, Chatham, Bibb and

SPECIAL ARTICLE / Continued

Muscogee Counties. 270 MAG members are from the smaller cities and towns of Georgia. They belong to the MAG but are not members of the American Medical Association.

Imagine, 559 MAG members, who do not read the AMA Journal; who never see the AMA News; whose reception rooms contain no copies of Today's Health! How many of these men's wives belong to the Woman's Auxiliary? How many of them belong to AmPAC? How many belong to GaMPAC? These 559 members of the MAG are letting their brothers carry the load!

If these 559 MAG members, who are selling medicine short, would join the AMA we would not have just three Delegates and three Alternates representing Georgia. We would be just 16 members short of having five Delegates and five Alternates representing you in the greatest medical organization of all time. The House of Delegates of the AMA is the most democratic forum possible. It is in that forum that the rules are made that you work by; and it is there that the medical ethics that you live by are developed.

Just think, 559 Georgia physicians selling Georgia medicine short! 559 of our brothers selling American medicine short! Is it any wonder that Socialism is creeping in? One sixth of our MAG membership is dragging its feet! Are they the ones who so often say, "Government medicine is sure to come; we might as well make the best deal we can?" How often have you heard that or a similar statement?

I am stealing a quotation from our genial Speaker of the MAG House of Delegates. In the year of 1295 A.D. the first poet to write in the Italian language, the great Dante Allegheri, stated: "The innermost circle of Hell is reserved for those who, in the time of political turmoil and tyranny, stand aside and do nothing." Does that quotation apply to our 559 brothers? Does it apply to those others among us who do not even belong to the MAG?

Gentlemen, it is your problem. I am going to ask every Councilor, every county secretary, and every MAG Delegates to go back home and sell American medicine, sell memberships in AMA and MAG. It is the job of every one of you!

Politics and Medicine

Most of us would prefer to have nothing to do with politics. We would like to be let alone so that we could get on with our job of taking care of the sick and injured. However, the politicians, particularly the socialists, desire to take over medical practice. Therefore, we are today faced with another King-Anderson Bill. The present King-Anderson Bill was

introduced in both the House of Representatives, where it is known as H. R. 3920, and in the Senate where it is known as S. 880. The socialists have only to win one time and put one segment of medical practice under the Social Security System. It will be the end of an era which has produced the most efficient system of medical practice ever devised. The proof of this is in the morbidity and mortality statistics of the United States.

Therefore, each of you, and your wives, must be politicians. Belong to a political party — become precinct or county committeeman. Attend the state and national conventions of your party. Try to participate in the naming of all party candidates.

Kerr-Mills Implementation

In January 1962 hospital care was put in operation in Georgia for Old Age Assistance clients of the Department of Public Welfare. The program has constantly expanded and has been a great boon to these people. The hospitals have benefited from this program.

The legislature has passed the necessary enabling laws to start the Medical Assistance to the Aged program — MAA. Funds are not yet available but we have hope that they will be in the very near future.

The answer to Social Security health schemes (such as the King-Anderson Bill) is the Kerr-Mills program of both O.A.A. for the needy and M.A.A. for the "near needy," and voluntary health insurance for the rest of the aging population.

Aging

The American Medical Association has developed an eight point program which will bear repeating here. This program is designed to help achieve a better life for the Nation's aged;

1. Re-evaluation of attitudes toward the elderly.
2. Implementation and strengthening of the Kerr-Mills law.
3. Changes in the income tax laws to aid the aged.
4. Continued expansion of health insurance and repayment plans.
5. Recasting retirement policies.
6. Increase in nursing home facilities.
7. Expansion of community programs for the aged.
8. Emphasis on mental health among the aged.

Public Health Problems

The Epidemiologists have recently stated that we have permitted small pox immunization levels to drop too low. A massive epidemic of small pox could easily develop. Yellow fever could come in by air travel.

A recent development of an effective method of immunization for measles could be a great help in controlling this disease and its sequelae.

The emphasis being placed on Mental Health by all parties, the President, The American Medical Association, and others, should result in better control of this important problem.

In the decade 1950 to 1960, there was a 44 per cent drop in the death rate from high blood pressure and related heart diseases, and a 22 per cent drop in stroke death rates. This occurred in men ages 45 through 64. The prime of life. The improved death rates extend into the 65 to 74 age group.

Reliable estimates indicate that infectious syphilis (reported and unreported) occurs in the United States at the rate of 60,000 cases per year. The number of gonorrhea cases is estimated at one million.

All of these problems require the attention of the entire medical profession. They cannot be solved by the Departments of Public Health alone.

Hospitals

Today the hospital is playing an increasing role in medical care. Most of the sick and injured of any consequence are cared for in hospitals.

Hospitals built in 1959 and 1960 cost about \$17,000 per bed and the average new facility has 86 beds. The average construction cost, without equipment, was \$1,500,000.00—These figures are from the U. S. Bureau of Labor Statistics.

A medical "Statesman" of 30 years ago made the statement that, "The physician with his little black bag could adequately take care of 95 per cent of all human ills." This certainly is no longer true.

Many general hospitals have been built in areas where it was impossible to have an adequate staff. When this occurs it is a terrific economic waste. A program developed thru the Georgia Hospital-Medical Council should be pushed—that is, the examination and accreditation of the small hospitals.

Medical Education

In the field of Medical Education there are many complex problems, and there is no one answer.

Last year in the United States there were 7,168 graduates in medicine. This is the largest number of graduates in modern times in any one year. These 7,168 graduates are expected to fill 12,074 approved

internships, and 36,712 approved residencies. In addition there are constantly increasing full-time jobs in teaching, research, public health services, military services, veterans services and so on ad infinitum.

One of the Deans of a large medical school recently stated that, "One cannot separate teaching, research, patient care and community service." This statement is certainly true. There is a great question that must be answered. Does the present exaggerated emphasis on research thrust on the schools primarily by the Federal Government, throw the whole problem out of balance? Does it add up to the best medical care for the sick and injured of the State of Georgia?

Georgia is a state wide in area. The two medical schools graduated a total of 143 doctors of medicine in 1962. Emory University 63 and the Medical College of Georgia 80. Certainly both schools should increase the facilities and the size of their graduating classes, so that in ten years there would be nearer 300 graduate M.D.'s annually. If this is not feasible, then another medical school should be developed, perhaps in Macon.

It has been suggested and discussed by the Medical Association of Georgia's Board of Medical Education that a Southeastern Conference on Medical Education should be held. This should be sponsored by the Medical Colleges, the Medical Association of Georgia and the American Medical Association.

Only 28 per cent of the 2,068 Alumni of the Medical College of Georgia graduates through 1961 called themselves General Practitioners?

One of the big problems in Education is the continuing education of the physicians in practice. Both of our Medical Schools are trying to meet this need.

"If all research were to be stopped today, it would take at least six years for the medical profession to catch up." This statement is attributed to Dr. Sam Levine of Boston.

In this discussion today we have touched briefly on a few of the problems facing the Medical Association of Georgia and all physicians. What we are able to accomplish depends on you, the members.

I would like to close with a quotation from one of our better known Presidents, Woodrow Wilson. He stated:—"The history of liberty is the history of the limitation of Government, not the increase of it."

THE VALUE OF ADVERTISING

If there were no pharmaceutical advertising, new life-saving drugs would be withheld from the critically ill patients, either because we the physicians did not know the new drug existed or we did not know its exact indications and how to administer it safely and effectively.

The pharmaceutical industry is having to carry the Herculean load of protecting its livelihood, and providing the world with these life-saving remedies.

Texas State Journal of Medicine, October 1962.

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Carey, Floyd Thomas	Chatsworth, Georgia	Active	Whitfield
Carpenter, Robert H.	629 20th Street Columbus, Georgia	Active	Muscogee
Davis, Floyd L. O.	1617 Thompson Avenue East Point, Georgia	Active	Fulton
Dunaway, James Boyd	712 S. 8th Street Griffin, Georgia	Active	Spalding
Duval, Addison M.	47 Trinity Avenue Atlanta 3, Georgia	Active	Fulton
Edmonds, Marion	35 Lindon Avenue Atlanta 8, Georgia	Active	Fulton
Grossgart, Peter	3010 Hampton Street Brunswick, Georgia	Active	Glynn
Harris, Joseph H. W.	1444 Fourth Avenue Columbus, Georgia	Active	Muscogee
Hornik, Adolph R., Jr.	1364 Clifton Road, N.E. Atlanta 16, Georgia	Active	Fulton
Howard, Robert M.	202 East Hall Street Savannah, Georgia	Active	Ga. Med Soc.
Kelley, James H.	170 Spring Street Newnan, Georgia	Active	Coweta
Majoros, Marton	144 Ponce de Leon Avenue, N.E. Atlanta 8, Georgia	Active	Fulton
Moody, Richard A.	105 East Plum Street Jesup, Georgia	Active	Wayne
Ortega, Hernando	35 Lindon Avenue Atlanta 8, Georgia	Active	Fulton
Rhodes, Wm. H., Jr.	100 Scott Street Union Point, Georgia	Active	Oconee Valley
Robinson, Jerry Mason	80 Butler Street, S.E. Atlanta 3, Georgia	Active	Fulton
Sheehan, L., Clyde, Jr.	671 Hemlock Street Macon, Georgia	Active	Bibb
Sheely, Lowry L.	Eugene Talmadge Memorial Hospital Augusta, Georgia	Active	Richmond
Shumate, Robert E. L.	1951 8th Avenue Columbus, Georgia	Active	Muscogee
Smith, Henry Briggs	490 Peachtree Street, N.E. Atlanta 8, Georgia	Active	Fulton
Smith, William J.	Glynn Brunswick Hospital Brunswick, Georgia	Active	Glynn
Tidmore, Thomas L., Jr.	1364 Clifton Road, N.E. Atlanta 16, Georgia	Active	Fulton
Timms, Dicky W.	2 Medical Arts Center Savannah, Georgia	Active	Ga. Med. Soc.
Waddell, Pearl B.	1140 Ocean Boulevard St. Simons, Georgia	Active	Glynn
Wade, Leo J.	Madison, Georgia	Active	Oconee Valley
Walker, Ottis	Chatsworth, Georgia	Active	Whitfield

OFFICIAL PROCEEDINGS

109th Annual Session

of the

MEDICAL ASSOCIATION OF GEORGIA

Aquarama, Jekyll Island, Georgia

May 5-8, 1963

First Session, House of Delegates

Second Session, House of Delegates

First General Business Session

Second General Business Session

Third General Business Session

109TH MAG ANNUAL SESSION PROCEEDINGS INDEX

First Session, House of Delegates

Attendance	244
Reference Committees	244
Credentials and Tellers Committees	245
Approval of 1962 Minutes	245
Memorial Service	245
Annual Reports	246
General Practitioner of the Year Award	247
Supplementary Reports	247
Resolutions	247

Second Session, House of Delegates

Attendance	248
Report of Reference Committee No. 1	249
Report of Reference Committee No. 2	254
Report of Reference Committee No. 3	262
Report of Reference Committee No. 4	269
Report of Reference Committee No. 5	279
Reports, Reference Committee Recommendations, and Delegates' Action:	
President	249
President-Elect	250
Immediate Past President	250
First Vice President	250
Second Vice President	251
Secretary	254
Treasurer	255
Speaker of the House	257
Vice Speaker of the House	257
AMA Delegates	258
AMA Alternate Delegates	259
Council of MAG	271
First District Councilor	251
Second District Councilor	251
Third District Councilor	252
Fourth District Councilor	259
Fourth District Vice Councilor	260
Fifth District Councilor and Vice Councilor	260
Sixth District Councilor	268
Seventh District Councilor	269
Eighth District Councilor	263
Eighth District Vice Councilor	263
Ninth District Councilor	270
Tenth District Councilor	270
Bibb County Councilor	268
Fulton County Councilor	260
Fulton County Vice Councilor	261
Georgia Medical Society Councilor	252
Muscogee County Councilor	252
Muscogee County Vice Councilor	253
Richmond County Councilor	271
Richmond County Vice Councilor	271
Finance	265
Professional Conduct	268
Woman's Auxiliary Advisory	268
Annual Session	253

Constitution and Bylaws	272
Governmental Medical Services	263
Crippled Children Sub-committee	263
Disaster Medical Care Sub-committee	264
Maternal and Infant Welfare Sub-committee	264
Public Health Sub-committee	265
Hospital Activities	261
Blood Banks Sub-committee	261
Hospital Relations Sub-committee	262
Insurance and Economics	274
Relative Value Study Sub-committee	275
Interprofessional Relations	279
Legislation	275
Medical Education	279
AMA-ERF Sub-committee	279
Medical Education Sub-committee	280
Medical School Sub-committee	280
Public Service	280
Weekly Health Column Sub-committee	281
Public Service Sub-committee	281
Special Activities Board	283
Mental Health Sub-committee	281
Allied Reports:	
Report of the <i>Journal of MAG</i>	276
Woman's Auxiliary to the Medical Association of Georgia	283
Supplementary Report A (Cancer Sub-committee Activity)	285
Resolutions, Reference Committee Recommendations, and Delegates' Action:	
Resolution No. 1 (Gubernatorial Appointments to the Board of Medical Examiners)	269
Resolution No. 2 (Introduction of a Bill Properly Defining the Practice of Podiatry)	277
Resolution No. 3 (General Practice)	253
Resolution No. 4 (AMA Council on Medical Education)	284
Resolution No. 5 (Health Care of the Aged)	278
Resolution No. 6 (Cigarette Smoking)	284
Resolution No. 7 (Expansion of Georgia Kerr-Mills Program)	278
MAG General Business Session	
Nominations for Association Officers	288
Nomination for GP of the Year Award	289
Nominations for Hardman Award	289
MAG General Business Session (Second Session)	
President's Address and President-Elect's Address	289
MAG General Business Session (Third Session)	
Fifty Year Certificates	290
Scientific Exhibit Awards	290
GP of the Year Award	290
MAG Certificates of Appreciation	290
Hardman Award	290
Distinguished Service Award	290
Site of 1965 Annual Session	291
Election Results	291
Installation of Officers	291
Official Attendance Records	291

FIRST SESSION, HOUSE OF DELEGATES

SUNDAY, MAY 5, 1963

THE FIRST SESSION of the House of Delegates of the Medical Association of Georgia was called to order by Speaker J. Frank Walker, Atlanta, at 5:00 p.m. on May 5, 1963, in the Aquarama Meeting Room, Jekyll Island, Georgia, in conjunction with the 109th Annual Session of the Medical Association of Georgia.

Speaker Walker called for a preliminary report of the delegates' attendance. Braswell Collins, Macon, Chairman of the House of Delegates Credentials Committee, reported that there was a quorum of 40 members present and accounted for, and Speaker Walker then declared a quorum present and the House in official session. A complete report made by the Credentials Committee on the attendance at the First Session of the House of Delegates follows:

Attendance

In a compilation of attendance taken from the official roll, 50 county medical societies were represented by their duly elected delegates or alternates. Twenty-one medical societies were not represented at this First Session. Of a total of 146 authorized delegates from their respective medical societies, the official roll showed 111 delegates present at this First Session.

BALDWIN: W. T. Smith; BIBB: Waddell Barnes, E. C. McMillan, Jule C. Neal, R. G. Newton, Jr.; BULLOCH-CANDLER-EVANS: Louis H. Griffin; BURKE, J. M. Byne, Jr.; CAMDEN-CHARLTON: G. W. Barker; CARROLL-DOUGLAS-HARALSON: J. I. Vansant, J. H. Beall; CHATTAHOOCHEE: Rupert Bramblett; CHEROKEE-PICKENS: C. J. Roper; CLAYTON-LAFAYETTE: F. A. Sams, Jr.; COBB: Remer Y. Clark, Robert P. Coggins, Donald R. Rooney, T. J. Vansant, Jr.; COLQUITT: A. G. Funderburk; DECATUR-SEMINOLE: Henry A. Bridges; DEKALB: John Heard, W. M. Kerr, M. F. Simmons, T. Q. Spitzer, M. Virginia Tuggle; DOUGHERTY: W. P. Rhyne, J. E. Cantrell; EMANUEL: R. J. Moye; FLINT: J. T. Christmas; FLOYD: R. E. Andrews, James H. Jenkins, Jack M. Waldrep; FULTON: T. J. Anderson, Linton H. Bishop, Milton F. Bryant, Walker L. Curtis, R. Carter Davis, F. W. Dowda, Charles Eberhart, Edwin C. Evans, Darius Flinchum, J. T. Godwin, J. E. Griffith, Chenault W. Hailey, J. H. Harrison, Fleming Jolley, W. D. Logan,

Jr., J. G. McDaniel, A. P. McGinty, J. D. Martin, J. C. Massee, W. W. Moore, Jr., W. P. Nicholson, III, W. J. Pendergrast, Lester Rumble, Jr., Paul Teplis, Robert E. Wells, Frank L. Wilson, Jr., William A. Wood; GEORGIA MEDICAL SOCIETY: John L. Elliott, W. H. Fulmer, Lawrence Lee, Fenwick Nichols, Jules Victor; GLYNN: C. S. Britt, C. A. Wilson; HABERSHAM: Bruce Swain; JACKSON-BARROW: P. T. Scoggins; LAMAR: John B. Crawford; LAURENS, W. A. Dodd; CRAWFORD LONG: F. M. McElhannon; McDUFFIE: A. G. LeRoy; MERIWETHER-HARRIS: W. P. Kirkland; MUSCOGEE: A. J. Kravtin, Bruce C. Newsom, Charles R. Smith; OCMULGEE: C. M. Johnson; OCONEE VALLEY: George F. Green; PEACH BELT: H. E. Weems; RANDOLPH-TERRELL: Robert B. Martin, III; RICHMOND: C. A. White, Jr., W. L. Shepard, H. D. Scoggins, J. T. Johnson, R. C. McGahee, W. A. Fuller, P. D. Ellington, J. B. Bowen, W. E. Barfield; SOUTH GEORGIA: Van B. Bennett, Robert L. Stump; SOUTHEAST GEORGIA: Robert W. Oliver; SOUTHWEST GEORGIA: H. L. Lassiter; SPALDING: Virgil B. Williams; STEPHENS: Irving D. Hellenga; SUMTER: J. H. Robinson, III; TELFAIR: C. J. Maloy; THOMAS-BROOKS: John B. Morton; TROUP: J. M. Grisamore, E. D. Wells; UPSON: T. A. Sappington; WALKER-CATOOSA-DADE: M. K. Cureton, J. P. Hoover; WALTON: Lynn M. Huie; WARE: F. E. Davis, W. L. Pomeroy; WAYNE: E. L. Harrell; WHITFIELD: F. F. Felker, Jr., David A. Wells; WILKES: A. W. Simpson; WORTH: W. P. Stoner.

County Medical Societies not represented at this session of the House of Delegates were as follows: ALTAMAHA, BARTOW, BEN HILL-IRWIN, BLUE RIDGE, COFFEE, COWETA, ELBERT-FRANKLIN-HART, GORDON, GRADY, HALL, JASPER, JEFFERSON, JENKINS, MITCHELL, NEWTON-ROCKDALE, POLK, RABUN, SCREVEN, TAYLOR, TIFT, and WASHINGTON.

Reference Committees

Speaker Walker appointed the following House of Delegates Reference Committees:

REFERENCE COMMITTEE NO. 1: Preston Ellington, Augusta, Chairman; T. J. Vansant, Marietta, Vice Chairman; Robert Oliver, Lyons. Secre-

tary; Bruce Newsom, Columbus; W. P. Rhyne, Albany; J. Miller Byne, Jr., Waynesboro; F. William Dowda, Atlanta; C. A. Wilson, Brunswick, and William B. Dillard, Cartersville.

REFERENCE COMMITTEE NO. 2: T. Q. Spitzer, Atlanta (DeKalb), Chairman; Jules Victor, Savannah, Vice Chairman; John B. Morton, Thomasville, Secretary; F. F. Felker, Jr., Dalton; A. J. Waters, Augusta; M. W. Williams, Camilla; J. H. Robinson, Americus; Tully T. Blalock, Atlanta, and Paul T. Scoggins, Commerce.

REFERENCE COMMITTEE NO. 3: I. D. Helenga, Toccoa, Chairman; W. L. Pomeroy, Waycross, Vice Chairman; R. Carter Davis, Atlanta, Secretary; John B. O'Neal, Elberton; Jack Waldrep, Rome; R. C. McGahee, Augusta; C. J. Maloy, McRae; E. D. Wells, Jr., LaGrange, and Waddell Barnes, Macon.

REFERENCE COMMITTEE NO. 4: William Moore, Atlanta, Chairman; Robert Coggins, Marietta, Vice Chairman; C. J. Roper, Jasper, Secretary; R. A. Chipman, Columbus; J. H. Deaton, Columbus; R. J. Moye, Swainsboro; E. C. McMillan, Macon; Van B. Bennett, Valdosta, and R. D. Roberts, Fitzgerald.

REFERENCE COMMITTEE NO. 5: Jule C. Neal, Macon, Chairman; C. M. Johnson, Eastman, Vice Chairman; F. M. McElhannon, Athens, Secretary; Robert Wells, Atlanta; Dan Jardine, Douglas; J. P. Hoover, Rossville; W. H. Fulmer, Savannah; E. L. Harrell, Jesup, and Virginia Tuggle, Decatur.

Credentials and Tellers Committees

Speaker Walker announced the prior appointments of the House of Delegates Credentials Committee and Tellers Committee as follows:

Credentials Committee: Braswell Collins, Macon, Chairman; Fleming Jolley, Atlanta, and Louis H. Griffin, Claxton.

Tellers Committee: Thomas J. Anderson, Atlanta, Chairman; L. O. J. Manganiello, Augusta, and F. A. Sams, Fayetteville.

Approval of 1962 Minutes

To expedite the reading and adoption of the minutes of the 1962 sessions of the House of Delegates held in conjunction with the 108th Annual Session of the Medical Association of Georgia meeting in Savannah, Georgia, on May 6-8, 1962, the Chair entertained the motion that the minutes as published in the June 1962 issue of the *Journal of the Medical Association of Georgia* be approved. On motion duly made and seconded, it was noted that these minutes be so approved as published in their entirety in the June 1962 issue of the *Journal of the Medical Association of Georgia*.

Memorial Service

Speaker Walker led the House of Delegates in the prayer of St. Francis of Assisi in memory of those Medical Association of Georgia members deceased during the past year. Following this prayer, Speaker Walker read the names of these departed colleagues: ERNEST ACKERLEY, Atlanta, March 30, 1963
GUY D. AYER, Madison, Florida, July 21, 1962
JAMES B. BAIRD, Atlanta, December 1, 1962
MARION TROTTI BENSON, Atlanta, June 7, 1962
J. H. BOLAND, Atlanta, February 9, 1963
WADE H. BORN, McRae, August 24, 1962
U. S. BOWEN, Los Angeles, California, January 24, 1963
REESE W. BRADFORD, Columbia, South Carolina, September 1, 1962
HARRY LANGDON CHEVES, SR., Union Point, September 29, 1962
M. B. COPELOFF, Atlanta, February 12, 1963
R. D. CRONE, Athens, February 25, 1962
ALTON WALKER DAVIS, Warrenton, October 7, 1962
EDGAR BROWN DAVIS, Byromville, November 20, 1962
N. M. DEVAUGHN, Augusta, December 12, 1962
JOHN BAXTER DUNCAN, Atlanta, May 15, 1962
R. E. L. ENGLISH, Griffin, July 1, 1962
W. P. EZZARD, Lawrenceville, January 29, 1963
J. A. FAULKNER, Augusta, January 11, 1963
A. K. FIDLER, Milledgeville, March 9, 1963
KIMSEY E. FOSTER, College Park, October 9, 1962
THOMAS NORMAN FREEMAN, JR., LaGrange, June 3, 1962
JOHN S. GIBSON, Atlanta, July 30, 1962
WARREN WALTER GREMMEL, Atlanta, April 1, 1962
HUGH HAILEY, Atlanta, January 13, 1963
FREDERICK W. HAMES, Cumming, September 16, 1962
HOLLIS HAND, LaGrange, March 14, 1963
WILLIAM R. HODGES, Thomasville, February 11, 1963
LOUIS HOLTZ, Carrollton, September 27, 1962
C. F. HOLTON, Savannah, April 30, 1963
ARTHUR LEE HORTON, Cartersville, May 4, 1962
PAUL LOVEJOY HUDSON, Atlanta, February 11, 1962
ANDREW JACKSON JONES, Jacksonville, June 2, 1962
L. H. KELLEY, Atlanta, April 13, 1963
CARL A. KLINE, Griffin, June 24, 1962
THOMAS E. McBRYDE, Rockmart, July 3, 1962
CHRISTOPHER J. McLOUGHLIN, Atlanta, June 4, 1962

J. L. MEEKS, Gainesville, January 7, 1963
 EDWARD S. MILLER, Rome, December, 1962
 JOYCE F. MIXSON, SR., Valdosta, January 11, 1963
 E. E. MOSELEY, Donalsonville, February 28, 1963
 HENRY H. OLLIFF, SR., Register, April 12, 1962
 DEWITT PRITCHETT, Barnesville, October 5, 1962
 H. L. SAMS, Dalton, March 4, 1963
 JOHN D. STILLWELL, Thomasville, January 7, 1963
 J. C. STONE, Doerun, May 15, 1962
 JAMES ANDREW THRASH, Columbus, May 21, 1962
 CHARLES USHER, Savannah, May 13, 1962
 EMMETT WARD, Ellenwood, October 4, 1962
 GEORGE ATTICUS WARD, SR., Elberton, February 25, 1962
 J. L. WEEKS, Harlem,
 SAMUEL DeWAITE WORK, JR., Macon, September 10, 1962
 JAMES CLEMENT WOOLRIDGE, Columbus, September 7, 1962
 SAMUEL YOUNGBLOOD, JR., Savannah, August 13, 1962
 WILLIAM G. SKIPPER, Atlanta, April 2, 1963

Annual Reports

Speaker Walker called for the Annual Reports of Officers, Council, Councilors and Vice Councilors, Association Committees and Boards and Sub-Committees.

(A cross reference of the reports of the Officers, Council, Councilors and Vice Councilors, Association Committees and Boards and Board Sub-Committees and Allied Reports as introduced at this session is listed below with the Reference Committee to which they were referred. The full report, the action by the Reference Committees, and the House of Delegates action is listed under the proceedings of the Second Session of the House of Delegates. See pages 248 to 285.)

REPORTS OF OFFICERS

President—Thomas W. Goodwin, Augusta—Reference Committee No. 1. See Page 249.

President-Elect—George R. Dillinger, Thomasville—Reference Committee No. 1. See Page 250.

Immediate Past President—Fred H. Simonton, Chickamauga—Reference Committee No. 1. See Page 250.

First Vice President—Lee Battle, Jr., Rome—Reference Committee No. 1. See Page 250.

Second Vice President—Walker L. Curtis, College Park—Reference Committee No. 1. See Page 251.

Secretary—John T. Mauldin, Atlanta—Reference Committee No. 2. See Page 254.

Treasurer—John S. Atwater, Atlanta—Reference Committee No. 2. See Page 255.

Speaker of the House—J. Frank Walker, Atlanta—Reference Committee No. 2. See Page 257.

Vice Speaker of the House—Joseph B. Mercer, Brunswick—Reference Committee No. 2. See Page 257.

AMA Delegates—J. W. Chambers, LaGrange; Henry Tift, Macon and Eustace Allen, Atlanta—Reference Committee No. 2. See Page 258.

AMA Alternate Delegates—George R. Dillinger, Thomasville and J. Frank Walker, Atlanta—Reference Committee No. 2. See Page 259.

REPORT OF COUNCIL

Report of Council—George H. Alexander, Forsyth, Chairman—Reference Committee No. 4. See Page 271.

REPORT OF COUNCILORS AND VICE COUNCILORS

First District Councilor—Charles Bohler, Brooklet—Reference Committee No. 1. See Page 251.

Second District Councilor—Frank McKemie, Albany—Reference Committee No. 1. See Page 251.

Third District Councilor—Frank A. Wilson, Leslie—Reference Committee No. 1. See Page 252.

Fourth District Councilor—Virgil B. Williams, Griffin—Reference Committee No. 2. See Page 259.

Fourth District Vice Councilor—Charles T. Cowart, LaGrange—Reference Committee No. 2. See Page 260.

Fifth District Councilor and Vice Councilor—Floyd R. Sanders, Decatur and L. P. Matthews, Atlanta—Reference Committee No. 2. See Page 260.

Sixth District Councilor—William Rawlings, Sandersville—Reference Committee No. 3. See Page 268.

Seventh District Councilor—Ralph N. Johnson, Rome—Reference Committee No. 4. See Page 269.

Eighth District Councilor—F. G. Eldridge, Valdosta—Reference Committee No. 3. See Page 263.

Eighth District Vice Councilor—J. W. Yeomans, Jesup—Reference Committee No. 3. See Page 263.

Ninth District Councilor—Charles R. Andrews, Jr., Canton—Reference Committee No. 4. See Page 270.

Tenth District Councilor—A. W. Simpson, Jr., Washington—Reference Committee No. 4. See Page 270.

Georgia Medical Society Councilor—Walter Brown, Savannah—Reference Committee No. 1. See Page 252.

Muscogee County Councilor—Willis P. Jordan, Sr., Columbus—Reference Committee No. 1. See Page 252.

Muscogee County Vice Councilor—Luther H. Wolff, Columbus—Reference Committee No. 1. See Page 253.

Fulton County Councilor—J. G. McDaniel, Atlanta—Reference Committee No. 2. See Page 260.

Fulton County Vice Councilor—Charles S. Jones, Atlanta—Reference Committee No. 2. See Page 261.

Bibb County Councilor—George H. Alexander, Forsyth—Reference Committee No. 3. See Page 268.

Richmond County Councilor—Harry D. Pinson, Augusta—Reference Committee No. 4. See Page 271.

Richmond County Vice Councilor—J. L. Mulherin, Augusta—Reference Committee No. 4. See Page 271.

REPORTS OF ASSOCIATION COMMITTEES

Finance—J. G. McDaniel, Atlanta, Chairman—Reference Committee No. 3. See Page 265.

Professional Conduct Committee—H. D. Allen, Jr., Milledgeville, Chairman—Reference Committee No. 3. See Page 268.

Woman's Auxiliary Advisory Committee—Ralph W. Fowler, Sr., Marietta, Chairman—Reference Committee No. 3. See Page 268.

REPORTS OF BOARDS AND SUB-COMMITTEES

Annual Session Board—Peter Hydrick, College Park, Chairman—Reference Committee No. 1. See Page 253.

Constitution and Bylaws—W. G. Elliott, Cuthbert, Chairman—Reference Committee No. 4. See Page 272.

Governmental Medical Services Board—Luther H. Wolff, Columbus, Chairman—Reference Committee No. 3. See Page 263.

Crippled Children Sub-Committee—E. B. Dunlap, Jr., Atlanta, Chairman—Reference Committee No. 3. See Page 263.

Disaster Medical Care Sub-Committee—Virgil B. Williams, Griffin, Chairman—Reference Committee No. 3. See Page 264.

Maternal and Infant Welfare Sub-Committee—Eugene L. Griffin, Atlanta, Chairman—Reference Committee No. 3. See Page 264.

Public Health Sub-Committee—R. W. Edenfield, Macon, Chairman—Reference Committee No. 3. See Page 265.

Hospital Activities Board—Milford B. Hatcher, Macon, Chairman—Reference Committee No. 2. See Page 261.

Blood Banks Sub-Committee—Jack C. Norris, Atlanta, Chairman—Reference Committee No. 2. See Page 261.

Hospital Relations Sub-Committee—Milford B. Hatcher, Macon, Chairman—Reference Committee No. 2. See Page 262.

Insurance and Economic Board—David R. Thomas, Jr., Augusta, Chairman—Reference Committee No. 4. See Page 274.

Relative Value Study Sub-Committee—Harry D. Pinson, Augusta, Chairman—Reference Committee No. 4. See Page 275.

Interprofessional Relations Board—J. G. McDaniel, Atlanta, Chairman—Reference Committee No. 5. See Page 279.

Legislation Board—Samuel U. Braly, Dallas, Chairman; J. Frank Walker, Atlanta, Chairman of National Legislation and John A. Bell, Dublin, Chairman, State Legislation—Reference Committee No. 4. See Page 275.

Medical Education Board—T. A. Sappington, Thomaston, Chairman—Reference Committee No. 5. See Page 279.

AMA-ERF Sub-Committee—Braswell E. Collins, Macon, Chairman—Reference Committee No. 5. See Page 279.

Medical Education Sub-Committee—Walter L. Bloom, Atlanta, Chairman—Reference Committee No. 5. See Page 280.

Medical School Course Sub-Committee—T. A. Sappington, Thomaston, Chairman—Reference Committee No. 5. See Page 280.

Public Service Board—Linton Bishop, Atlanta, Chairman—Reference Committee No. 5. See Page 280.

Weekly Health Column Sub-Committee—J. Rhodes Havery, Atlanta, Chairman—Reference Committee No. 5. See Page 281.

Public Service Sub-Committee—Floyd R. Sanders, Jr., Decatur, Chairman—Reference Committee No. 5. See Page 281.

Special Activities Board—John S. Atwater, Atlanta,

Chairman—Reference Committee No. 5. See Page 283.

Mental Health Sub-Committee—James N. Brawner, Jr., Atlanta, Chairman—Reference Committee No. 5. See Page 281.

ALLIED REPORTS

Journal of the Medical Association of Georgia—Edgar Woody, Jr., Atlanta, Editor—Reference Committee No. 4. See Page 276.

Woman's Auxiliary to the Medical Association of Georgia—Mrs. Ennis W. Waldemayer, Americus, President—Reference Committee No. 5. See Page 283.

General Practitioner of the Year Award

Speaker Walker presented the nominations received for the 1963 Georgia General Practitioner of the Year Award who was James C. Anderson of Macon. As there were no other nominations so made at the prior first General Session of the Medical Association of Georgia, Speaker Walker then entertained a motion that Dr. Anderson be unanimously elected as GP of the year for 1963 and instructed the Secretary to cast an unanimous ballot for Dr. Anderson.

Supplementary Reports

Speaker Walker then called for new business and the first order of new business requested was the supplementary reports from any Officers, Council, Councilors, Association Committees, Boards, Boards Sub-Committees or Allied Reports. The following supplementary report was received and introduced as follows:

Supplementary Report of the Sub-Committee on Cancer No. A: Cancer Sub-Committee Activity—Robert C. Pendergrass, Americus, Chairman—Reference Committee No. 5. See Page 285.

Resolutions

Speaker Walker called for the introduction of Resolutions as the second order of new business and the following Resolutions were so introduced:

Resolution No. 1: Gubernatorial Appointments to the Board of Medical Examiners, etc.—John B. O'Neal for Elbert-Franklin-Hart Medical Society—Reference Committee No. 3. See Page 269.

Resolution No. 2: Introduction of a Bill Properly Defining the Practice of Podiatry—Robert E. Wells for Fulton County Medical Society—Reference Committee No. 4. See Page 277.

Resolution No. 3: General Practice—J. Harvey Beall for Carroll-Douglas-Haralson Medical Society—Reference Committee No. 1. See Page 253.

Resolution No. 4: AMA Council on Medical Education—Lester Rumble, Jr. for Fulton County Medical Society—Reference Committee No. 5. See Page 284.

Resolution No. 5: Health Care of the Aged—William M. Moore, Jr. for Fulton County Medical Society—Reference Committee No. 4. See Page 278.

Resolution No. 6: Cigarette Smoking—John S. Elliott for Georgia Medical Society—Reference Committee No. 5. See Page 284.

Resolution No. 7: Expansion of Georgia's Kerr-Mills Program—Linton H. Bishop, Jr. for Fulton County Medical Society—Reference Committee No. 4. See Page 278.

Speaker Walker called for other Resolutions and there being none, he then called on President Thomas Goodwin.

President Goodwin introduced James W. Harkess of Augusta, Georgia, formerly of Edinburgh, Scotland, UK, who addressed the MAG House of Delegates on the subject "Socialized Medicine."

Following the address by Dr. Harkess, Speaker Walker then called the first meeting of the MAG House of Delegates recessed at 6:30 p.m.

SECOND SESSION, HOUSE OF DELEGATES

(Recessed)

WEDNESDAY, MAY 8, 1963

THE SECOND SESSION (Recessed) of the House of Delegates of the Medical Association of Georgia held in conjunction with the 109th Annual Session of the Association was called to order by Speaker J. Frank Walker at 9:10 a.m., Wednesday, May 8, 1963, in the Aquarama Meeting Hall, Jekyll Island, Georgia.

Speaker Walker called on Credentials Committee Chairman Braswell Collins for preliminary report of attendance. Dr. Collins reported that more than 40 members of the House of Delegates were registered as present and Speaker Walker then declared a quorum present and accounted for, and the House of Delegates in session. Dr. Collins made the following complete report on attendance at the close of the meeting:

Attendance

In a compilation of attendance taken from the official roll, 45 county medical societies were represented by their duly elected delegates or alternates. Twenty-six county medical societies had no representatives at the Second Session. Of a total of 146 authorized delegates from their respective medical societies, the official roll showed 99 delegates present at this Second Session.

BALDWIN: G. L. Echols, Jr., W. T. Smith; BIBB: Waddell Barnes, Braswell Collins, Jule C. Neal, E. C. McMillan; BULLOCH-CANDLER-EVANS: Louis H. Griffin; CARROLL-DOUGLASHARALSON: J. H. Beall, J. I. Vansant; CHATTAHOOCHEE: Rubert Bramblett; CHEROKEE-PICKENS: C. J. Roper; CLAYTON-FAYETTE: F. A. Sams, Jr.; COBB: Remer Y. Clark, Robert P. Coggins, T. J. VanSant, Donald R. Rooney; COL-

QUITT: A. G. Funderburk; DECATUR-SEMINOLE: Henry A. Bridges; DEKALB: W. K. Kerr, M. F. Simmons, M. Virginia Tuggle; DOUGHERTY: J. E. Cantrell; EMANUEL: R. J. Moyer; FLINT: J. T. Christmas; FLOYD: R. E. Andrews, James H. Jenkins, J. M. Waldrep; FULTON: T. J. Anderson, Linton H. Bishop, Milton F. Bryant, A. G. Churchwell, Walker L. Curtis, R. Carter Davis, F. W. Dowda, Charles Eberhart, Darius Flinchum, T. J. Florence, J. E. Griffith, Chenault W. Hailey, Fleming Jolley, Joseph C. Massee, Park McGinty, W. W. Moore, W. J. Pendergrast, Lester Rumble, Jr., Paul Teplis, Robert Wells, Frank L. Wilson, Jr., W. D. Logan, J. G. McDaniel, W. P. Nicholson, III, W. A. Wood; GEORGIA MEDICAL SOCIETY: Lawrence Lee, Fenwick Nichols, H. E. Puckett; GLYNN: C. S. Britt, C. A. Wilson; HABERSHAM: Bruce Swain; JACKSON-BARROW: Paul T. Scoggins; JENKINS: W. W. Hillis, Jr.; LAMAR: John B. Crawford; CRAWFORD LONG: F. M. McElhannon; McDUFFIE: A. G. LeRoy; MERIWETHER-HARRIS: W. P. Kirkland; MUSCOGEE: J. H. Deaton, A. J. Kravtin, Bruce Newsom, Charles R. Smith; OCONEE VALLEY: George F. Green; RICHMOND: W. E. Barfield, P. D. Ellington, W. A. Fuller, Thomas W. Goodwin, Menard Ihnen, J. T. Johnson, R. C. McGahee, W. L. Sheppard, C. A. White; STEPHENS: Irving D. Hellenga; SOUTH GEORGIA: H. L. Lassiter; SPALDING: Virgil B. Williams; SUMTER: J. H. Robinson, III; TELFAIR: C. J. Maloy; THOMAS-BROOKS: John B. Morton; TROUP: E. D. Wells, J. M. Grisamore; UPSON: N. P. Gardner; WALKER-CATOOSA-DADE: M. K. Cureton, J. P. Hoover; WALTON:

R. E. Welzel; WARE: F. E. Davis, W. L. Pomeroy; WASHINGTON: W. S. Helton; WAYNE: E. L. Harrell; WILKES: A. W. Simpson; WHITFIELD: David A. Wells, F. F. Felker, Jr.

County medical societies not represented at this Second Session of the House of Delegates were as follows: ALTAMAHA, BARTOW, BEN HILL-IRWIN, BLUE RIDGE, BURKE, CAMDEN-CHARLTON, COFFEE, COWETA, ELBERT-FRANKLIN-HART, GORDON, GRADY, HALL, JASPER, JEFFERSON, LAURENS, MITCHELL, NEWTON-ROCKDALE, OCMULGEE, PEACH BELT, POLK, RABUN, RANDOLPH-TERRELL, SCREVEN, TAYLOR, TIFT, and WORTH.

Reference Committee Reports

Speaker J. Frank Walker stated the next order of business would be the Reference Committee Reports.

Report of Reference Committee No. 1

Preston Ellington, Augusta, Chairman

(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 1 met in the Rotunda of the Aquarama, Jekyll Island, Georgia, at 8:00 a.m., May 6, 1963. Members present were: Preston Ellington, Augusta, Chairman; R. J. Vansant, Marietta, Vice Chairman; Robert Oliver, Lyons, Secretary; F. William Dowda, Atlanta; W. P. Rhyne, Albany; C. A. Wilson, Brunswick; Bruce Newsome, Columbus; and J. Miller Byne, Jr., Waynesboro.

President

THOMAS W. GOODWIN, M.D., Augusta

This year has been a busy and rewarding one for me as your president. It has involved much traveling and the expenditure of much time in order to serve you properly. These inconveniences I do not regret. I knew what I was getting into when I was elected. I only hope that the verdict of time will show you that you were wise in your choice.

In June I went along with our other representatives from the Medical Association of Georgia to Washington to pay our annual call on our congressmen and senators. Later in that month it was my pleasure to attend the annual meeting of the American Medical Association in Chicago. There I took part with our other representatives in the workings of the House of Delegates. I also took part with the presidents of the other state associations in the inauguration of the new president of the American Medical Association. I have made numerous personal appearances and speeches over the state, have attended all the meetings of the Executive Committee and Council, and as many of the district society meetings as time would permit.

Our Association has had a good year. Our fiscal position remains sound, our committees on the whole have functioned well, and we have had a good degree of success in our legislative programs. We have seen the Kerr-Mills law come into successful fruition and have been able to expand its benefits in the field of old-age assistance. I would like to urge the Medical Association of Georgia to lend its every effort to the further expansion of this law in the field of medical aid to the aged, and would urge the House of Delegates to pass such a resolution and forward it to the Governor.

We have also been able to increase our liaison, with the State Board of Health. We assisted the members of this board in the recodification of the health laws for the state.

We have also come to a better understanding with the State Board of Medical Examiners and have taken long steps in the working out of some of our mutual difficulties in the field of medical practice and ethics. We have reorganized and made more workable the State Medicare Review Board, and we have made considerable progress in the evaluation of some of our insurance programs. We have provided new impetus to our mental health programs and have appointed several new members, as well as a new chairman of that committee. We have assisted in the revision of the State Board of Workmen's Compensation schedules. We have considered in Council the enlargement of the House of Delegates, which consideration you will see in the Report of Council. I recommend it highly for your consideration. We have strengthened the organization of our headquarters staff to provide new and improved services to the membership.

It is needless for me to say that these things could not have been accomplished without the help and support of all concerned. My particular thanks go out to the chairmen and members of our committee, our Executive Committee, and our Council. These agencies have truly made our organization a working organization and have brought the Medical Association of Georgia a long way in the past few years. Our headquarters' office staff continues to function efficiently and has been a great help to me. To them, also, go my thanks. To our members, who never cease to amaze me with their ability to respond to every task that confronts them, goes my particular gratitude for giving me the privilege of serving you.

The presidency of this association is an arduous task, and some way is going to have to be eventually found to lighten this load. This could perhaps be accomplished by increasing the activities and importance of the office of the two vice presidents. If they could be utilized more efficiently within the framework of our organizational structure, some of the load on the president could be eased. This problem I leave to you.

Lastly, let me say that whatever the future holds for us, both individually and collectively as doctors, I am sure that we will not be weighed in the balances and found wanting.

REFERENCE COMMITTEE RECOMMENDATION—The Committee accepts and approves with commendation, the President's report. The Committee approves the expansion of the Kerr-Mills Program in Georgia as recommended in the President's report. The Committee wishes to thank the President for his untiring efforts in behalf of the members of the Medical Association of Georgia.

HOUSE OF DELEGATES ACTION—Adopted the report of the President as recommended by the Reference Committee on motion duly made and seconded.

President-Elect

GEORGE R. DILLINGER, M.D., *Thomasville*

The Medical Association of Georgia during the past year has made excellent progress. Every mandate of the House of Delegates has been carried out except in a very few instances. This will be reported to the annual session and these instances are due to legal or economic reasons.

The recent change in the size of the Council, giving the larger society more equitable representation, is working very efficiently. Every member of the Council is to be commended for their attendance and interest in the activities of the Association. Members of the Executive Committee have rarely been absent from any meetings and the business of the Association has been conducted very efficiently. The President, Dr. Goodwin; Secretary, Dr. Mauldin, and the entire headquarters staff are to be commended for their interest and activity in our interest. *The Journal of the Medical Association of Georgia* continues in its high standards under the able direction of Dr. Edgar Woody, the Editor.

The Medical Association of Georgia must continue to undergo constant change, because of a changing economy and constant increase in political pressures.

It is important that we especially emphasize the following in the coming year:

1. Continue with every possible means to activate medical assistance to the aged under the Kerr-Mills legislation.

2. Follow-up the Physical Fitness of Youth meeting recently held, with continued action and attempt to have the State Department of Education help to activate the program throughout the school systems of Georgia.

3. Work closely with each of the Medical Schools on a problem of undergraduate Medical Education and attempt to increase the size of the graduating classes.

4. Keep constantly before us the problem of Continuing our Graduate Medical Education for the benefit of all the doctors of Georgia.

5. Promote in every way the education and training of paramedical personnel.

6. Continue to increase our activity in the field of both state and national legislation.

7. Continue our efforts to work closely with industry, labor, and agricultural organizations so that better understanding will follow.

8. Continue our efforts for closer liaison with paramedical and health organizations.

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves and commends the President-Elect for his report.

HOUSE OF DELEGATES ACTION—Adopted the report of the President-Elect as recommended by the Reference Committee on motion duly made and seconded.

Immediate Past President

FRED H. SIMONTON, M.D., *Chickamauga*

As we approach the time for our Annual Session which is the climax of the 109th year of activity of the Medical Association of Georgia, it is timely that I express my appreciation to our President, Dr. Thomas W. Goodwin, who has worked so diligently and for the splendid job he has done, and to our Secretary for his able assistance, members of the Headquarters Staff and the Officers and Council for their good work and the manner in which all Boards and Committees have functioned. Each recommendation made by our President has been carried out as he directed. These recommendations and actions will be covered in other reports to be found in the Medical Association of Georgia Delegates Handbook.

Thank you for affording me the privilege of serving as President of the Medical Association of Georgia during last year. As Immediate Past President, I have carried out every duty and function and have attended every Executive Committee and Council meeting during the past year.

I want to reiterate to the entire membership of the Medical Profession of Georgia that we are now facing the greatest challenge which has ever confronted free medicine. We in the United States are a part of the only great power in the world which has free enterprise medicine. It is, therefore, a challenge to each of us to renew his efforts to see that we maintain our free enterprise system. This effort is important from the local, the state and the national levels, and I urge each member to execute renewed interest in this field. WE CAN ONLY LOSE ONCE!

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves and commends the Immediate Past President for his report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Immediate Past President as recommended by the Reference Committee.

First Vice President

LEE H. BATTLE, JR., M.D., *Rome*

I have attended all of the Council meetings and most of the Executive Committee meetings even though I do not have a vote in this meeting. The recommendation has been made to amend the Bylaws to provide that the Vice President be made a full member of the Executive Committee. I am heartily in favor of this. I have not been assigned any specific jobs to do in connection with being the Vice President.

The only recommendation that I have is to make a little better use of the vice presidents. I can't say that I have served any useful purpose other than to be available should the President become unable to serve for some reason.

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves and commends the First Vice President for his report with approval of the recommendation of Council that the First Vice President be made a full voting member of the Executive Committee of Council.

HOUSE OF DELEGATES ACTION—Adopted the report of the First Vice President as recommended by the Reference Committee on motion duly made and seconded.

Second Vice President

WALKER L. CURTIS, M.D., *College Park*

Attended all MAG Council meetings during the year.

Attended 1962 AMA Convention in Chicago, participating in committee conferences and assisting in making reports at MAG breakfast meetings.

Attended AMPAC Seminar in Chicago, and dinner conference, June 24, 1962.

Attended Conference for County Society Officers on the Public be Served: "Youth Fitness for 1963" and "Politics and Medicine in 1963," March 8th and 9th, in Atlanta.

Submitted a Resolution to MAG Council, in connection with Community Service. The Resolution, which was passed by Council, approved the sponsoring by Medical Societies of Explorer Posts in Medicine, Specialty Units. Fulton County Medical Society is sponsoring the organization of a Pilot Specialty Unit. Nine physicians are now trained for its leadership. Much interest and appreciation is being shown by the Explorers and by the school authorities.

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves and commends the Second Vice President for his report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Second Vice President as recommended by the Reference Committee on motion duly made and seconded.

First District Councilor

CHARLES E. BOHLER, M.D., *Brooklet*

The annual First District Medical Society meeting is to be held at the Forest Heights Country Club in Statesboro on March 27. We feel honored in that our guest speaker is to be Dr. Lester Dragstedt, former Professor of Surgery at the University of Chicago and now Professor of Research Surgery at the University of Florida.

We are anticipating a good attendance from the First District and the Georgia Medical Society of Savannah.

I feel that the First District membership is quite aware of the problems and responsibilities we of the medical profession are facing.

I have attended all regular and called meetings of Council.

I hope that each society in the District will have a delegate at the Annual Session at Jekyll Island.

Counties and Secretaries	Members December 31, 1962		Members December 31, 1961	
	MAG	AMA	MAG	AMA
Bulloch-Candler-Evans				
R. S. Robinson				
Metter	19	17	22	19
Burke				
Charles G. Green				
Waynesboro	7	5	8	6
Emanuel				
H. R. Frost				
Swainsboro	7	6	7	6
Jenkins				
A. P. Mulkey				
Millen	3	3	2	2

Screven

J. C. Freeman				
Sylvania	7	7	5	5
Southeast Georgia				
Michael H. Whittle				
Lyons	24	19	22	17
Tri-Liberty-Long-				
McIntosh				
O. D. Middleton				
Ludowici	5	4	2	1
	72	61	68	56

Charles Bohler

Councilor

Brooklet

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves and commends the First District Councilor for his report.

HOUSE OF DELEGATES ACTION—Adopted the report of the First District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Second District Councilor

W. FRANK MCKEMIE, M.D., *Albany*

It was an honor to accept appointment as Councilor for the Second District Medical Society following the resignation of Dr. George Dillinger in April, 1962. During 1962 and 1963 your Councilor has attended regular meetings of the Council of the Medical Association of Georgia; accompanying a group of Georgia physicians to Washington in June to meet with our Congressional Delegation and discuss medical legislation; accepting appointment on the Georgia Hospital-Medical Council which inspects small hospitals; in the Georgia Senate and House in February to meet members of the state legislature and to discuss legislation affecting the medical profession; participating in proceedings of the Medical Association of Georgia in Savannah in May 1962.

Meetings of the Second District Medical Society have continued to be held regularly and this is a growing and vital medical organization and a growing section of the state. The list of Second District members attached below will reflect this growth.

It is our opinion, too, that the officials of the Medical Association of Georgia and the permanent staff of the Medical Association are continuing to produce a sound and progressive program for medicine in Georgia.

Counties and Secretaries	Members December 31, 1962		Members December 31, 1961	
	MAG	AMA	MAG	AMA
Colquitt				
Walter E. Harrison				
Moultrie	19	18	19	16
Decatur-Seminole				
M. A. Ehrlich				
Bainbridge	17	15	17	15
Dougherty				
A. O. Goldsmith				
Albany	53	42	47	37
Grady				
C. K. Singleton				
Cairo	5	5	5	5

Mitchell				
A. A. McNeill, Jr.				
Camilla	11	9	11	9
Southwest Georgia				
R. E. Jennings				
Arlington	14	12	14	12
Thomas-Brooks				
Julian B. Neel				
Thomasville . . .	46	40	42	36
Tift				
C. S. Pittman, Sr.				
Tifton	15	10	15	9
Worth				
H. G. Davis, Jr.				
Sylvester	4	4	5	4
	184	155	175	143

W. Frank McKemie
Councilor
Albany

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves and commends the Second District Councilor for his report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Second District Councilor as recommended by the reference Committee on motion duly made and seconded.

Third District Councilor

FRANK A. WILSON, M.D., *Leslie*

The Third District has seven organized Societies. The level of activity has improved during the past year. The Randolph-Terrell Society has been reorganized and has planned quarterly meetings. Sumter County Medical Society has also planned regular meetings. Flint, Peach Belt, Ocmulgee and Ben Hill-Irwin Societies are active and having regular programs. No report received from Taylor.

The Fall meeting of the District Society was held in Cordele with the Flint Medical Society serving as host. The Spring meeting will be held in Montezuma.

The Councilor has attended all regular meetings of the Council and the County Society Officers Conference.

Counties and Secretaries	Members December 31, 1962		Members December 31, 1961	
	MAG	AMA	MAG	AMA
Ben Hill-Irwin				
Ralph D. Roberts				
Fitzgerald	9	8	8	7
Flint				
W. Kelvin Lane				
Ashburn	15	14	17	14
Peach Belt				
J. R. Arnall				
Perry	29	25	28	24
Ocmulgee				
Blake S. Bivins				
Cochran	15	11	14	11
Randolph-Terrell				
Carl E. Sills				
Cuthbert	12	10	12	9
Sumter				
H. L. Simpson				
Americus	22	18	22	19

Taylor				
E. C. Whatley				
Reynolds	4	2	4	2
	106	88	105	86
Frank A. Wilson				
Councilor				
Leslie				

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves and commends the Third District Councilor for his report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Third District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Georgia Medical Society Councilor

WALTER BROWN, M.D., *Savannah*

The Georgia Medical Society has had another successful year. Attendance has been markedly improved by a lively social hour preceding the scientific meeting with interesting and timely scientific papers presented by prominent local and visiting doctors.

The Society both sponsored and participated in several programs sponsored by civic and professional groups to bring before the public the many problems and conditions facing the medical profession today and how these will directly affect them in the immediate future.

These primarily concerned the proposals by the government to enact the King-Anderson bill; and reasons for opposition by the medical profession. At the same time the provisions of the Kerr-Mills bill were explained and why it is supported by the profession.

The Society entertained in May the Medical Association of Georgia annual convention. We feel that this was one of our most successful annual meetings both from social and scientific angles.

Dr. Charles Prince was installed as incoming president for 1963 at the December meeting.

Dr. John K. Train, outgoing president, was honored at a reception by the Society in March 1963 and was presented the president's pin.

Your Councilor has attended all meetings of Council and of the Georgia Medical Society during the past year.

Counties and Secretaries	Members December 31, 1962		Members December 31, 1961	
	MAG	AMA	MAG	AMA
Georgia Medical Society				
Jeff L. Holloman				
Savannah	152	137	153	138
Walter Brown				
Councilor				
Savannah				

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves and commends the Georgia Medical Society Councilor for his report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Georgia Medical Society Councilor as recommended by the Reference Committee on motion duly made and seconded.

Muscogee County Councilor

WILLIS P. JORDAN, SR., M.D., *Columbus*

The Executive Committee of the Society has been

informed constantly of business of the Association. Any business thought necessary was discussed at open meeting. There is a slight increase in membership of MAG and AMA over last year.

Counties and Secretaries	Members		Members	
	December 31, 1962 MAG	AMA	December 31, 1961 MAG	AMA
Muscogee				
C. Denton Johnson				
Columbus . . .	109	102	107	99
W. P. Jordan				
Councilor				
Columbus				

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves and commends the Muscogee County Society Councilor for his report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Muscogee County Society Councilor as recommended by the Reference Committee on motion duly made and seconded.

Muscogee County Vice Councilor
LUTHER H. WOLFF, M.D., *Columbus*

The Vice Councilor of the Muscogee County Medical Society attended all Council Meetings except one during the past year. Working in conjunction with the Councilor of Muscogee County Medical Society, Dr. W. P. Jordan, it was arranged that every meeting be covered by one or the other of the representatives of the Muscogee County Medical Society.

The Vice Councilor attended the Senate Committee hearing on the Podiatrist Bill and testified before this committee.

From time to time, various pertinent matters taken up by Council have been reported to the officers of the Muscogee County Medical Society.

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves and commends the Muscogee County Society Vice Councilor for his report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Muscogee County Society Vice Councilor as recommended by the Reference Committee on motion duly made and seconded.

Annual Session

PETER HYDRICK, M.D., *Chairman*

The committee representing the Annual Session Board met in Savannah on two occasions. The first meeting was held with the Chairman on Commercial Exhibits and the representative of Shepard Decorating Company. The selection of the DeSoto Hotel was the site for the meeting because of its new facilities since our last meeting there, plus the services offered, and the fact that a majority of the membership prefers to meet in downtown Savannah. However, the space for commercial exhibits was limited to hospital size exhibits only. This had never been done before in Georgia. Other states were contacted, as well as representatives of commercial houses, and they felt that it would decrease the sale of booth spaces. The Council of MAG was contacted and gave their permission for this new venture. The representatives of the specialty societies were also gathered for a meeting and the combination of groups for the Scientific Sessions worked out. A

second visit to Savannah was necessary to organize the local arrangements committee and also to meet with the officers and representatives of the Woman's Auxiliary. The meeting, according to reports, was a success, and the sale of commercial exhibits was excellent.

The Council of MAG elected to hold the 1963 Annual Session on Jekyll Island. There have been two trips to this area to arrange for the meeting. The first trip was to meet with representatives of Shepard Decorating Company, to map out floor plans for the commercial exhibits in the Aquarama and to arrange the main meeting hall in the Aquarama. Two other meeting rooms were arranged in the Holiday Inn. On this same trip the representatives of the specialty societies were called together and combinations of these groups were arranged for the scientific session. On the second trip the previous arrangements were confirmed and the local arrangements committee was organized and their plans placed in detail, as well as meeting with the representatives of the Woman's Auxiliary. At this meeting it was also decided that it was necessary to limit commercial exhibits to hospital exhibit size. The Annual Session Board hopes that this meeting will be as successful as the one last year.

The Chairman of the Annual Session Board has no particular recommendations to make. However, it is unfortunate that in the State of Georgia it is impossible to house a convention the size of MAG under one roof for commercial exhibits and scientific sessions, except in one city. This makes it difficult to arrange meetings and, therefore, many members are not always satisfied with the arrangements that are made, but the Chairman wishes to state that he has done the best he could with what facilities were available. Physicians of influence could be of service by encouraging the mayors of the cities without convention bureaus to establish same.

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves and commends the chairman of the Annual Session Board for his activities and work. Committee would like to recommend that Council consider and investigate the feasibility and advisability of holding the Annual Session at two alternating resort areas in the State of Georgia.

HOUSE OF DELEGATES ACTION—Adopted the report of the Annual Session Board as recommended by the Reference Committee on motion duly made and seconded.

Resolution No. 3
GENERAL PRACTICE
J. HARVEY BEALL FOR CARROLL-DOUGLASS-HARALSON MEDICAL SOCIETY

Whereas, the general practitioner of medicine is logically the patients first source of general health care and first line of defense against disease and injury, and

Whereas, the competent and progressive practitioner of general medicine is and should be the basic foundation of medical practice, and

Whereas, there is an apparent shortage, relative and absolute, of such physicians, both now and predicted for the future;

Now, therefore, be it resolved that the Carroll-Douglass-Haralson Medical Society believes that there is a great and continuing need for the general physician—both for the welfare of the general public and of the profession—(this being increasingly attested to by po-

litical leaders, medical specialty groups, medical general practice groups, and others);

And this Society urges before this Assembly that the Medical Association of Georgia, primarily on behalf of the people of the state, take prompt and adequate action as indicated to investigate and report on this situation with particular attention to the state medical schools and academic attitudes toward the general practice of medicine and, further, to make appropriate recommendations to improve the number and quality of general practitioners of medicine in this state.

REFERENCE COMMITTEE RECOMMENDATION—The Committee accepts and approves this Resolution with the recommendation that it be referred to the Medical Education Board.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 3: General Practice, as recommended by the Reference Committee on motion duly made and seconded.

It was moved by the Chairman of the Reference Committee No. 1, Preston Ellington, Augusta, and duly seconded that the report of Reference Committee No. 1 be approved as a whole and it was so ordered.

Report of Reference Committee No. 2

T. Q. Spitzer, DeKalb, Chairman

(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 2 met in the Rotunda of the Aquarama, Jekyll Island, Georgia, at 8:00 a.m., May 6, 1963. Members present were: T. Q. Spitzer, Atlanta, Chairman; Jules Victor, Savannah, Vice Chairman; John B. Morton, Thomasville, Secretary; J. H. Robinson, Americus; Tully T. Blalock, Atlanta; Paul Scoggins, Commerce, and Julius Johnson, Augusta.

Secretary

JOHN T. MAULDIN, M.D., Atlanta

The work of the MAG from the Secretary's viewpoint has made excellent progress. Since the defeat of the King-Anderson Bill in the Senate last year, national legislation has not been as active as in previous years. However, a similar bill has been introduced in Congress and we cannot afford to be caught asleep. The increased legislative and political activity in the field of medicine continues to emphasize the necessity for 100 per cent participation of all the doctors in Georgia. Every doctor should support GaMPAC. The MAA portion of the Kerr-Mills Law should be activated in Georgia and the Medical Association of Georgia should continue to make every effort to support this program.

Hospital-Medical Council

This organization has increased its activity. The inclusion of the Hospital-Medical Council's standards for smaller hospitals as a part of the Welfare Department's Program has greatly increased its activity. During the past year about 20 hospitals have been inspected and

some 15 to 20 more are in the process of being inspected. Thus, it is hoped that within the next year every hospital in Georgia that desires an evaluation will have received adequate recognition.

The first edition of "Standards for Smaller Hospitals" has been exhausted, necessitating a second edition. This new edition is being extensively revised and should be available by the time this report is published. Monies for this publication have been received from the Medical Association of Georgia and the Georgia Chapter of the American College of Surgeons. The work of this Council alleviated the necessity for the Family Service Department to promulgate rules and regulations concerning standards for hospitals when the Kerr-Mills program was implemented in Georgia.

Dr. Charles Cowart of LaGrange has served as Chairman during the past year and I wish to commend Dr. Cowart for his excellent work.

Medicare

The Medical Association of Georgia has continued to operate the physicians' portion of the Medicare Program in Georgia under contract with the Department of Army. This contract has been renewed with the approval of the Executive Committee and a new contract signed in February of this year. The only change from the old contract being to increase the amount allowable in newborn care to the physician who delivered the baby.

The rules and regulations have been revised during the year to make the Executive Committee of Council the final reviewing authority instead of the State Review Board, also to extend to any doctor the privilege of appearing in his own behalf before the Executive Committee in adjudication of a claim. The disbursements of this program are included in the Treasurer's Report.

The Adult Recipient Program

The Kerr-Mills Program has completed its first full year of operation in Georgia. The program began with ten days of hospitalization for acute illness only. On January 1, it was expanded to 15 days hospitalization and to include two elective procedures, prostatic resection and cataract removal. The second major expansion occurred on July 1, 1962. At this time, hospitalization was expanded to 30 days per admission and 60 days per calendar year. The contract with the Medical Association of Georgia was expanded to include similar services for the total and permanently disabled program and the aid to the blind program.

Total hospital bills paid — 11,640
(1/1/62-12/31/62)

Total money spent for hospital bills — \$777,145.92
(1/1/62-12/31/62)

This has been a most successful program due to the close cooperation of the Family Service Department, hospital administrators and doctors.

Headquarters Office

As Secretary I have coordinated the administrative problems of the Headquarters Office and have handled the correspondence on matters related to the medical policy not within the jurisdiction of other officers and

committees. The Headquarters Office has functioned well and has been most cooperative due to the foresightedness and excellent judgment of the Executive Secretary, Mr. Milton Krueger; the Associate Executive Secretary, Mr. Jim Moffett and the Assistant Executive Secretary, Mrs. Catherine Wooten.

Headquarters Office Building

The Headquarters Office Building has been used at least twice a week as a meeting place for MAG and allied organizations. No major repairs have been necessary during the past year. A stove and sink have been installed in the utility room thus improving greatly the facilities for serving lunches during meetings. The building has provided a center for MAG statewide activities and has been adequate background for the enhancement of the Association's sphere of influence.

MAG Membership

Active—2,646; Active Dues Exempt—353; Service Members—51; Associate Members—25; Total—3,075.

Summary

I wish to express my appreciation for the cooperation of the Officers and Members of the Medical Association of Georgia, particularly Dr. Tom Goodwin of Augusta, President; Dr. George Alexander, Forsyth, Chairman of Council. I have not encountered a single individual who was not willing to resolve his problems by frank and open discussion. All of the recommendations that I have made for the past year have been discussed with Committee and Board Chairmen within whose jurisdiction they fall.

REFERENCE COMMITTEE RECOMMENDATION—The Secretary's report was carefully reviewed. The Committee would like to commend Dr. Mauldin for his efforts in behalf of the Association this past year. This report was accepted as presented.

HOUSE OF DELEGATES ACTION—Adopted the report of the Secretary as recommended by the Reference Committee on motion duly made and seconded.

Treasurer

JOHN S. ATWATER, M.D., *Atlanta*

The report of the auditors, Ernst and Ernst, is attached. This audit covers the period ending the calendar year December 31, 1962. It is to be pointed out that the Association is in good financial condition, in fact, the best position in many years. While the overhead expenses have increased, there has also been an increase in income sufficient to meet these obligations.

I should like to thank most sincerely all those who have had a part in the conduct of the office of the Treasurer and especially our most efficient bookkeeper, Miss Thelma Franklin.

ERNST & ERNST

FIRST NATIONAL BANK BUILDING
ATLANTA 3, GA.

Chairman of the Council
The Medical Association of Georgia
Atlanta, Georgia

We have examined the statement of assets and liabilities of the several funds of The Medical Association of Georgia as of December 31, 1962, and the related statements of income and expenses and fund equities for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances. While it was not practicable to confirm the amount due from the United States Government with respect to the Medicare Fund, we have satisfied ourselves as to this balance by means of other auditing procedures.

In our opinion, the accompanying statement of assets and liabilities and the statements of income and expenses and fund equities present fairly the financial position of the several funds of The Medical Association of Georgia at December 31, 1962, and the results of operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Ernst & Ernst

Atlanta, Georgia
February 6, 1963

STATEMENT OF ASSETS AND LIABILITIES — BY FUNDS

The Medical Association of Georgia
Year Ended December 31, 1962

ASSETS

GENERAL FUND

Cash:		
Demand deposits	\$ 6,587.09	
Savings deposits (including \$6,250.00 restricted for property repairs and replacement)	61,250.00	\$ 67,837.09
Accounts receivable:		
Advertisers of The Journal	\$ 3,247.61	
Other accounts	625.00	3,872.61
Property and equipment—on the basis of cost:		
Buildings—mortgaged	\$110,954.72	
Furniture and equipment	23,837.23	
	<u>\$134,791.95</u>	

Less allowances for depreciation	36,952.46	
	<u>\$ 97,839.49</u>	
Land—mortgaged	80,000.00	177,839.49
		<u>\$249,549.19</u>
ABNER W. CALHOUN LECTURESHIP FUND		
Cash	\$ 155.71	
Corporation stocks (quoted market prices \$5,096.38)—at cost	6,101.85	6,257.56
		<u>6,257.56</u>
MEDICARE FUND — DEPARTMENT OF THE ARMY		
Cash	\$ 23,741.17	
Due from United States Government—service fees paid to physicians and dentists	61,258.83	85,000.00
		<u>\$340,806.75</u>

**The Medical Association of Georgia
Year Ended December 31, 1962**

LIABILITIES AND EQUITIES

GENERAL FUND

Liabilities:

Note payable to insurance company, \$4,000.00 installment, with interest at 5%, due on January 1, each year— secured by loan deed on land and buildings		\$ 23,000.00
Excess of claim fees received over claim expenses:		

United States Government—Medicare	\$ 2,995.88	
Old Age Assistance Welfare Program	173.46	3,169.34

Advance collections:

1963 membership dues	\$ 1,953.50	
1963 exhibit space payments	3,631.25	5,584.75

Fund equity:

Restricted:

Regular operating purposes	\$ 20,000.00	
Lecture expenses	421.42	

	<u>\$ 20,421.42</u>	
Unrestricted	197,373.68	217,795.10
		<u>\$249,549.19</u>

ABNER W. CALHOUN LECTURESHIP FUND EQUITY

6,257.56

MEDICARE FUND — DEPARTMENT OF THE ARMY

Advance from United States Government	85,000.00
	<u>\$340,806.75</u>

STATEMENT OF FUND EQUITIES

**The Medical Association of Georgia
Year Ended December 31, 1962**

	Balance Jan. 1, 1962	Income in Excess of Expenses	Fund Transfers	Balance Dec. 31, 1962
GENERAL FUND				
Restricted for operating purposes	\$ 20,000.00	\$ -0-	\$ -0-	\$ 20,000.00
Restricted for lecture expenses	660.01	500.00*	261.41	421.42
Unrestricted	183,399.45	13,974.23	-0-	197,373.68
	<u>\$204,059.46</u>	<u>\$13,474.23</u>	<u>\$ 261.41</u>	<u>\$217,795.10</u>
ABNER W. CALHOUN LECTURESHIP FUND	6,265.06	253.91	\$ 261.41*	6,257.56
TOTAL	<u>\$210,324.52</u>	<u>\$13,728.14</u>	<u>\$ -0-</u>	<u>\$224,052.66</u>

*Indicates red figure.

STATEMENT OF INCOME AND EXPENSES — BY FUNDS

The Medical Association of Georgia
Year Ended December 31, 1962

	General Fund	Abner W. Calhoun Lectureship Fund
INCOME		
Medical Association of Georgia dues	\$105,875.00	\$ -0-
Advertising — The Journal	38,141.11	-0-
Subscriptions — The Journal (non-members)	1,178.00	-0-
Exhibitors' fees — 1962 annual meeting	8,175.00	-0-
Interest income	2,058.51	-0-
Dividends — corporate stocks	-0-	267.67
American Medical Association refund	875.85	-0-
TOTAL INCOME	\$156,303.47	\$ 267.67
EXPENSES		
Fixed allotments	\$ 9,270.10	\$ -0-
Association office	73,222.89	-0-
Medical Association of Georgia committees	7,605.33	-0-
1962 annual session	7,254.73	-0-
The Journal	44,976.19	-0-
Trustees' fees	-0-	13.76
TOTAL EXPENSES	\$142,329.24	\$ 13.76
EXCESS OF INCOME OVER EXPENSES	\$ 13,974.23	\$ 253.91

REFERENCE COMMITTEE RECOMMENDATION—The Treasurer's report was carefully studied and approved as presented.

HOUSE OF DELEGATES ACTION—Adopted the report of the Treasurer when the Reference Committee report as a whole was adopted.

Speaker, House of Delegates

J. FRANK WALKER, M.D., *Atlanta*

The legislative body of the Medical Association of Georgia, the House of Delegates, approved 35 separate actions on various subjects at its 1962 Session in Savannah.

Each proposal, after study, and after consultation with Council as to disposition, was referred to the appropriate officer, staff executive, Council board or committee for action.

Several reviews were accomplished during the year to determine whether or not the wishes of the House of Delegates were indeed being accomplished. Stimuli to activity were applied when and where needed.

Several actions, of course, are still in progress and the intentions of others were carried out in alternative manners under Council direction.

Thoughts are being entertained at this time relative to direct representation in the House of Delegates for the general practice and specialty groups, medical school faculties, state health officers and Veterans Administration medical staffs.

The interests of the House of Delegates have been represented at each Council meeting by your Speaker and/or Vice-Speaker. If one were ever indispensable, it is Vice-Speaker Joe Mercer.

It continues to be a matter of concern that some of the smaller counties still do not avail themselves of representation in the House of Delegates. Furthermore, several delegates each year ignore the all-important voting Second Session. Any physician, delegate or not, is needed at the deliberations of the various reference committees when he is knowledgeable on the subject at issue. The success of our entirely democratic form of legislative government reflected in the House of Delegates, representing each and every physician in the state, depends on active participation and individual initiative.

REFERENCE COMMITTEE RECOMMENDATION—This report was carefully studied and approved as presented. We would like to thank Dr. J. Frank Walker for his diligent service in behalf of the Association.

HOUSE OF DELEGATES ACTION—Adopted the report of the Speaker of the House as recommended by the Reference Committee on motion duly made and seconded.

Vice-Speaker, House of Delegates

JOSEPH B. MERCER, M.D., *Brunswick*

The Vice-Speaker has attended every Council meeting during the past year. He has assisted the Speaker in every way possible and stands ready to carry out any

assignment for the good of the Medical Association of Georgia.

REFERENCE COMMITTEE RECOMMENDATION—The report was carefully studied and approved as presented. We would like to thank Dr. Joseph Mercer for his diligent service in behalf of the Association.

HOUSE OF DELEGATES ACTION—Adopted the report of the Vice Speaker of the House as recommended by the Reference Committee on motion duly made and seconded.

AMA Delegates

J. W. CHAMBERS, M.D., *LaGrange, Chairman, 1963*

HENRY H. TIFT, M.D., *Macon*

EUSTACE A. ALLEN, M.D., *Atlanta*

To the officers and members of the House of Delegates of the Medical Association of Georgia:

Your AMA Delegation for the past year has attempted to effectively represent you in the House of Delegates of the American Medical Association. All of your elected delegates have attended both the 111th Annual Association meeting in Chicago in June, 1962, as well as the Clinical session held in Los Angeles, California in November, 1962. With the help of your president and the secretary of the Association and the Assistant Executive Secretary and the Executive Secretary, as well as some members of the Medical Association of Georgia who have been in attendance at both of these meetings, we have been able to cover reasonably effectively the reference committee as well as the meetings of the House of Delegates. As most of you may know, we make a sincere attempt to cover every reference committee meeting during both the Annual Session and the interim session so that the Medical Association of Georgia may have a voice in any deliberations which are carried on before each reference committee of the House of Delegates of the American Medical Association. In this connection, we feel that it might be well to mention that as soon as the Medical Association of Georgia deems it financially feasible to do so, it would be most helpful to the delegates to the AMA if the alternate delegate could be provided with the same stipends for each session of the House of Delegates of the AMA as are the delegates in order to encourage the alternate delegates to attend each meeting. We believe this would greatly facilitate and help in the functioning of the Georgia delegation in the House of Delegates of the AMA.

As most of you have had the opportunity to read in the AMA News, the actions of significance in both the Annual Session in June and the Clinical Session in November, I will not attempt to outline these in detail. One of the most important reports which was brought before the House of Delegates in the June meeting was the report of the ad hoc committee on increasing the number of members of the Board of Trustees of the AMA. This was debated at great length and was finally voted and passed. This necessitated a change in the Constitution and Bylaws of the AMA; it had to lie over for a final vote in the Clinical Session in November, 1962. At the November session, it was brought to a vote after considerable discussion and debate and considerable opposition from the Board of Trustees of the AMA, but the vote carried by a majority of those delegates seated; through

a technicality, the Speaker did not note that the vote had to be carried by not only a majority of the delegates which were in the House and voting, but it had to be carried by a minimum of votes by those who were registered and seated, and unfortunately this had failed by some three to five votes, as I remember, and consequently did not constitute a legal quorum for the vote; by that time a sufficient number of the delegates had departed from the meeting and it was not possible to have a re-vote at that time. It was then voted by the House that the first order of business of the Annual Session to be held in June, 1963, in Atlantic City would be a vote on the change of the Constitution and Bylaws of the AMA to enlarge the Board of Trustees to a total of fifteen members. This seemed to be the overwhelming desire of the House of Delegates, as it appeared to your delegation at the time of the vote, both in Chicago and in Los Angeles.

The chairman of your delegation would strongly urge the House of Delegates of the Medical Association of Georgia to urge your membership at home for more of them to attend the meetings of the AMA, both Annual and Clinical Sessions. These meetings are not only of a great deal of interest insofar as their legislative activities are concerned, but they are of considerable interest from the standpoint of clinical value and I believe any member of the Medical Association of Georgia can profit by attending either or both of these sessions. I should also like to remind the members of the House of Delegates of the Medical Association of Georgia to also remind their constituent members at home, that when they do attend these meetings of the AMA, that they by all means register with the headquarters room of the Medical Association of Georgia at the headquarters hotel and leave their address at the hotel of the meeting so that we might be able to contact them in the event of need. Many times this can be a great deal of help to your delegation in the House of Delegates of the AMA.

Finally, I take this opportunity to express the appreciation of your delegation to the headquarter's staff from Mr. Krueger, Mr. Moffet, Mrs. Wooten, and the other members of the headquarter's staff who contributed so much to making our task of representing you much easier. May I also assure you that it is an honor, I feel, that is keenly felt by each member of your delegation to represent you in the House of Delegates of the AMA, and please be assured that our first desire will always be to represent the doctors who are members of the Medical Association of Georgia.

AMA Delegates

HENRY H. TIFT, M.D., *Macon, Chairman, 1962*

EUSTACE A. ALLEN, M.D., *Atlanta*

J. W. CHAMBERS, M.D., *LaGrange*

The Annual Session of the American Medical Association for 1962 was held in Chicago, June 24th through 28th. All sessions of the House of Delegates were attended by all three of the Medical Association of Georgia delegates. Dr. Tift served on the reference committee on Public Health and Occupational Health. As usual, the Georgia delegation held breakfast meetings on the second and third days of the session to discuss the various items of business that were to come

before the House. These meetings were also well attended by those officers of the Medical Association of Georgia who were in Chicago and by the MAG staff members.

Complete reports of the actions of the House of Delegates at this meeting are recorded elsewhere. The House voted to increase the number of members on the Board of Trustees of the AMA from eleven to fifteen members. A proposal to establish an American Board of Abdominal Surgery was defeated by the House.

Dr. George M. Fister, of Ogden, Utah, took over as President of the American Medical Association. Dr. Edward R. Annis, of Miami, Florida, well-known spokesman for the AMA in the campaign against the King-Anderson bill, was chosen President-elect of the Association. Dr. J. P. Culpepper, Jr., of Hattiesburg, Mississippi, was named Vice President to succeed our own Dr. Eustace A. Allen.

The interim session of the American Medical Association was held in Los Angeles, November 25th through 28th. Again, all three Georgia delegates attended all sessions of the House. Probably the most important business of this session was a report by the committee to study the Scientific Sections. This committee recommended major changes in the organizational structure and scientific program of the Association. However, because of many requests for delay in approval, the House instructed the Speaker to appoint an ad hoc Committee composed of members of the House, and including representatives of the sections, to study the subject and report at the 1963 Annual Session.

We again urge all members of the Medical Association of Georgia to join the American Medical Association and take advantage of the many services offered by this organization.

As representatives of the Medical Association of Georgia on the national level, we welcome suggestions and constructive criticism by MAG members.

Alternate Delegate

GEORGE R. DILLINGER, M.D., *Thomasville*

The complex activities of the House of Delegates of the American Medical Association, require the presence of a maximum delegation from each state. Very often six to eight important committee sessions are occurring at the same time, and Georgia should be represented in each of these reference committee sessions. The changing policy of the Medical Association of Georgia this year concerning payment of travel expenses for alternate delegates should insure maximum representation at all meetings.

Alternate Delegate

J. FRANK WALKER, M.D., *Atlanta*

My term of office as Alternate AMA Delegate did not begin until January 1, 1963. Since that time, of course, there have been no meetings of the House of Delegates of the American Medical Association. However, I have attended the past two meetings of the American Medical Association in the capacity of a member of an AMA Council. As such, I have been privileged to observe the functions of the House of Delegates, and I have attended the fine breakfast

meetings sponsored by our Georgia Delegation. I have participated, in a small way, in the deliberations of the Reference Committees. It is my intention to attend the Atlantic City and other scheduled meetings of the House of Delegates.

REFERENCE COMMITTEE RECOMMENDATION—The Committee agrees with Dr. J. W. Chambers' report in its entirety. We would like to specifically express our agreement that the full expenses of the Alternate Delegates to the AMA be paid. We feel that this will encourage fuller representation at AMA meetings.

We approve and commend Dr. Henry Tift for his report and we agree with him that all members of the Medical Association of Georgia who are not members of the American Medical Association should be encouraged to join. We feel that this will give us an increased number of Delegates from MAG.

HOUSE OF DELEGATES ACTION—Adopted the report of the AMA Delegates and Alternates as recommended by the Reference Committee on motion duly made and seconded.

Fourth District Councilor

VIRGIL B. WILLIAMS, M.D., *Griffin*

The Councilor of the Fourth District has attended all regular and called meetings of the Council during the past year.

Formal and informal consultations have been held with members of the Association residing in the Fourth District. During the year the Councilor has remained in contact with activities of all societies in his district. Problems of organization and ethics assigned to the Councilor have been completed or are in the process of completion at this time. The Councilor has attended all meetings of the Fourth District Medical Society and is at present serving as president of that organization.

The Councilor has been ready at all times to advise on problems pertaining to the office.

Counties and Secretaries	Members December 31, 1962		Members December 31, 1961	
	MAG	AMA	MAG	AMA
Clayton-Fayette				
Wells Riley				
Jonesboro	4	4	5	5
Coweta				
Robert P. Taylor				
Grantville	16	13	17	11
Lamar				
S. B. Traylor				
Barnesville	3	3	4	4
Meriwether-Harris				
H. Calvin Jackson				
Manchester	14	9	14	9
Newton-Rockdale				
T. L. Crews				
Covington	11	8	11	8
Spalding				
T. L. Lipscomb				
Griffin	40	35	43	36
Troup				
J. F. Krafka				
LaGrange	39	33	40	35
Upton				
W. P. Woodall				
Thomaston	15	12	15	11
	142	117	149	119
Virgil B. Williams				
Councilor				
Griffin				

REFERENCE COMMITTEE RECOMMENDATIONS—The Reference Committee approves and commends the report of the Fourth District Councilor.

HOUSE OF DELEGATES ACTION—Adopted the report of the Fourth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Fourth District Vice Councilor

CHARLES T. COWART, M.D., *LaGrange*

During the past year, the Fourth District Vice Councilor has attended all meetings of Council. He has attended all the District Society meetings except one. He is now serving as the District Chairman for GaMPAC. He is also Chairman of the Georgia Hospital-Medical Council.

This Vice Councilor would like to remind every physician of the State of Georgia of his responsibility to his profession as well as to his patients. It is to be emphasized that he must take an active interest in organized medicine so that he will not become a member of regimented medicine. He is already up to his nose in politics whether he is willing to recognize it or not. Get to know your legislators in the General Assembly of Georgia and in the National Congress. Tell them the story for organized medicine again and again.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee approves and commends the report of the Fourth District Vice Councilor.

HOUSE OF DELEGATES ACTION—Adopted the report of the Fourth District Vice Councilor as recommended by the Reference Committee on motion duly made and seconded.

Fifth District Councilor and Vice Councilor

FLOYD R. SANDERS, JR., M.D., *Decatur*

LAWRENCE P. MATTHEWS, M.D., *Atlanta*

The Fifth District Medical Society has experienced another year of medical growth and prosperity. The membership of all component societies has increased, and many of its members continue to receive wide recognition for contributions to medical literature.

The annual meeting of the Fifth District Society, on November 1, 1962, was one of the best attended affairs in the history of the society. The guest speaker was Colonel George M. Knauf, USAF, Medical Corps and his subject was "Medical Aspects of Manned Space Flight Operations—A Physician to the Astronauts." Dr. Frank Walker was elected President, and Dr. Carl C. Jones continues as Secretary-Treasurer for another year.

The activities of Fulton County Medical Society will be covered by its own Councilor and Vice Councilor.

The DeKalb County Medical Society continues its growth in a phenomenal fashion and is meeting the medical responsibilities imposed on it by our community. The major part of its medical activity has been centered around DeKalb General Hospital which is doing a magnificent job of meeting the medical needs of this area. The DeKalb County Medical Society continues to support the Fifth District Society by 100 per cent of its members.

Through the able support and assistance of your Fifth District Vice Councilor, Dr. L. P. Matthews, your Councilor has been privileged to attend all meetings of Council.

Counties and Secretaries	Members December 31, 1962		Members December 31, 1961	
	MAG	AMA	MAG	AMA
DeKalb				
M. Hobson Rice				
Decatur	126	108	115	99
Floyd R. Sanders				
Councilor				
Decatur				

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee approves and commends the report of the Fifth District Councilor and Vice Councilor.

HOUSE OF DELEGATES ACTION—Adopted the report of the Fifth District Councilor and Vice Councilor as recommended by the Reference Committee on motion duly made and seconded.

Fulton County Councilor

J. G. MCDANIEL, M.D., *Atlanta*

Fulton County has had a good year. The meetings have been fairly well attended. The programs have been excellent.

The polio "shot" clinic held last summer was eminently successful—over fifteen hundred children were immunized.

Over two hundred high school coaches and principals attended a meeting in the Academy of Medicine. Our program this year was "Conditioning of the High School Athlete."

Within the past year we have installed an emergency call system. Doctors volunteer for this service and either see the patient themselves or direct them on how to get medical attention. This has, so far, been more satisfactory than any other system that we have tried.

The Atlanta Graduate Medical Assembly was an outstanding scientific session and our attendance was excellent.

Several public forums have been held in the Academy. The Stroke Forum generated more interest than all others combined. Many were turned away because of lack of space.

We think our monthly Bulletin is outstanding. Several years ago it won the American Medical Writers Association award for excellence.

I have had a busy year as Councilor. By virtue of being Chairman of Finance I am on the Executive Committee. Council meets every three months. Executive Committee meets every month. I have attended all these meetings.

Dr. Charlie Jones, the vice councilor, continues to be a sturdy pillar to lean upon. He has done and is doing a masterful job in medical defense. Unfortunately, this job is getting bigger and more important each year.

Counties and Secretaries	Members December 31, 1962		Members December 31, 1961	
	MAG	AMA	MAG	AMA
Fulton				
T. J. Anderson, Jr.				
Atlanta	940	728	947	724

J. G. McDaniel
Councilor
Atlanta

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee approves and commends the report of the Fulton County Medical Society Councilor.

HOUSE OF DELEGATES ACTION—Adapted the report of the Fulton County Medical Society Councilor as recommended by the Reference Committee on motion duly made and seconded.

Fulton County Vice Councilor

CHARLES S. JONES, M.D., *Atlanta*

During the year 1963 I have served as the Vice Councilor for Fulton County to the Medical Association of Georgia. This has been an eventful year with many activities in the various fields of endeavor of your Council. In the capacity of Vice Councilor I have also served as Chairman of the medical defense committee. This has been an active year in this regard. Of practical importance to all of us will be the annual negotiation of contract with our insurance carrier, Saint Paul-Mercury Indemnity Companies. This meeting will be held March 30th, which is beyond the deadline of the present report. For that reason, a supplementary report will be filed to give the members a summary of the meeting which is to be held on March 30, 1963.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee approves and commends the report of the Fulton County Medical Society Vice Councilor.

HOUSE OF DELEGATES ACTION—Adapted the report of the Fulton County Medical Society Vice Councilor as recommended by the Reference Committee on motion duly made and seconded.

Hospital Activities

MILFORD B. HATCHER, M.D., *Chairman*

The Board of Hospital Activities has not had any controversial problems that were particularly unusual. Each Sub-Committee has functioned well and has taken care of the problems as presented.

There is one problem which has disturbed the Chairman of the Board of Hospital Activities, namely, the fact that practically all hospitals that are being constructed now are using federal government money and are thus indirectly under an obligation to the federal government and any control which it might desire to place upon such hospital.

It is my feeling that a method of matching funds for construction of hospitals be investigated by the medical profession and ways and means devised so that federal control over the practice of medicine would not someday become a fact. It is recommended that the medical profession attempt to find some manner of financing hospital construction without having governmental obligations.

REFERENCE COMMITTEE RECOMMENDATION—The report of the Hospital Activities Board Chairman was approved as presented, and the Committee recommends that the Association follow Dr. Milford Hatcher's suggestion that concrete means toward local financing of hospital construction be investigated so that same manner of financing other than governmental financing can be

used. The Committee would like to commend Dr. Hatcher for this report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Hospital Activities Board as recommended by the Reference Committee on motion duly made and seconded.

Blood Banks Sub-Committee

JACK C. NORRIS, M.D., *Chairman*

The meeting of the MAG Sub-Committee on Blood Banks was called to order by Chairman Jack C. Norris at 12:30 p.m., February 20, 1963, in Room 1014 at the Biltmore Hotel, Atlanta, Georgia.

Sub-Committee members present included Chairman Norris, Atlanta; Dr. Walter Shepard, Medical College of Georgia, Augusta; and Dr. Irving Greenberg, Atlanta. Also present at the meeting were Dr. Joseph W. Iseman, Atlanta, representing the American Red Cross; and Dr. S. C. Rutland, representing the Georgia Department of Public Health. Mr. James M. Moffett, Assistant Executive Secretary, MAG, attended as staff for the Sub-Committee.

Minimum Standards for Blood Banks

Following the luncheon, Chairman Norris made a few introductory remarks in which he explained that one of the important reasons for this meeting was to consider progress being made on the establishment of minimum standards for blood banks in Georgia. He pointed out that this project had been assigned to the Blood Banks Sub-Committee by the Speaker of the MAG House of Delegates pursuant to an action taken by the House.

Dr. Shepard discussed this undertaking with the Sub-Committee pointing out several legal aspects of blood transfusion service from the donor to the recipient of the blood. General discussion followed in which many of the pertinent areas to be covered by the minimum standards were explored. Dr. Shepard was urged to complete his work on these standards as soon as possible. In the interim, the Chairman requested Dr. Iseman to draft a set of working standards that may be used until the official MAG standards are drawn, approved and distributed.

Blood Banks Investigation Unit

Following general discussion of the need for a separate unit of the Georgia Department of Public Health, charged with the responsibility for investigating hospital blood banks, the following resolution (Greenberg-Shepard) was adopted:

"Be it resolved by the Sub-Committee on Blood Banks, Medical Association of Georgia, Jack C. Norris, Chairman, and the members: That the Health Officer, Department of Health, State of Georgia, be requested to proceed to establish in the department, a division entitled: 'State Health Department of Blood Banking,' this unit to be under the direction of either a Pathologist, Clinical Pathologist, Hematologist or a licensed doctor who is recognized as a person capable of placing the division into proper perspective and development; whose other duties as the Director, shall be to investigate, inspect, and cooperate with State located hospitals or clinics whose staff administer blood to patients, or who may desire to have them do so at a future date; to certify same, and to draw plans for the proper storage of blood and its therapeutic con-

stituents which may be needed in emergency; to further determine the operative fitness of hospitals having blood banks, including technical efficiency, to the extent that the public and the patients shall be protected; to cooperate with the American Red Cross and The American Association of Blood Banks; that legal steps to the establishment of this department be duly presented to the next available Legislature, in order that lawful status may be enacted to execute and promote the intent and purpose of this Resolution."

Laurens County Problem

Mr. Moffett advised the Sub-Committee that they had been requested by the MAG Executive Committee to examine the facts involved in a recent blood transfusion matter in the Laurens County Hospital. He also pointed out that the MAG Executive Committee wished to have a report from the Sub-Committee on the question of whether or not the procedure followed in this instance was of such a nature that the general education of the physicians in Georgia might be benefited by any of the Sub-Committee's conclusions.

On motion duly made and seconded (Greenberg-Shepard) the following resolution was adopted:

"Be it resolved that it is the judgment of the Sub-Committee on Blood Banks that no specific case concerning the giving of blood should be considered by the Sub-Committee. Further, that this Sub-Committee is not set up to function in this capacity, but rather it sees itself as being organized for the purpose of establishing standards for transfusion service."

Enlargement of Sub-Committee

Dr. Norris advanced the idea that this Sub-Committee might be more perfectly constituted by the addition of two new members giving the Sub-Committee a membership of five rather than its present three.

Following discussion of this idea, the following resolution (Greenberg-Shepard) was adopted:

"Be it resolved that the Executive Committee of MAG be requested to enlarge the membership of the Sub-Committee on Blood Banks by the addition of Dr. Joseph Iseman (American Red Cross) as an ex-officio member, and Dr. S. C. Rutland (Georgia Department of Public Health) as a member."

Hospital Memorandum

Chairman Norris requested and received, concurrence by the other members of the Sub-Committee to send to every hospital in Georgia a copy of a memorandum on the subject of "Hospital Transfusion Committees." The memorandum reads as follows: "Memorandum to all Hospitals in Georgia: The Sub-Committee on Blood Banks, Medical Association of Georgia, wishes to recommend to and urge all hospitals in the State who receive and administer BLOOD TRANSFUSIONS to appoint a 'TRANSFUSION COMMITTEE' on their Staffs composed of three persons, preferably a surgeon, an internist, and a member of the Laboratory. Essentially this Committee would cooperate with the blood bank in every respect in order to enhance its safety and performance, and particularly to investigate every REACTION occurring after blood has been given to a patient, reporting same to the Sub-Committee, or the American Red Cross Blood Bank, Atlanta, Georgia.

There being no further business before the Sub-Committee, Chairman Norris adjourned the meeting at 3:20 p.m.

REFERENCE COMMITTEE RECOMMENDATION—Blood Banks Sub-Committee report was studied in its entirety and the following recommendations and observations were made:

(1) Under the Section on Minimum Standards for Blood Banks, the Committee was informed that at this time there is a set of standards compiled by the American Association of Blood Banks which is in use and is considered acceptable by the Georgia Association of Pathologists. The Committee recommends that the use of this set of standards be continued until such time as MAG has the opportunity to review the report of its own Sub-Committee on Blood Banks.

(2) Under the Section on Blood Banks Investigation Units, it is recommended that the Resolution of the Sub-Committee relative to the establishment by the State Health Department of a Department of Blood Banking be disapproved.

(3) Under the heading of the Laurens County Problem, it is recommended that the Resolution of the Sub-Committee be approved as written.

(4) Under the Section on enlargement of the Sub-Committee on Blood Banks, it is recommended that the Resolution of the Sub-Committee be disapproved as written, and be amended as follows:

"the Sub-Committee should be enlarged to five members, of which at least two members should be clinical pathologists selected from names submitted by the Georgia Association of Pathologists."

(5) Under the Section on Hospital Memorandum, it is recommended that the individual hospital recognize their own problems and set up mechanisms and standards to rectify these problems. It is strongly recommended that these be done under the supervision of a physician rather than a Committee.

HOUSE OF DELEGATES ACTION—Adopted the recommendations of the Reference Committee in approving, disapproving, and amending portions of the report of the Sub-Committee on Blood Banks on motion duly made and seconded.

Hospital Relations Sub-Committee

MILFORD B. HATCHER, M.D., *Chairman*

It is felt that all problems referred to this Committee have been investigated. The Committee investigated the fact that there would be no intensive therapy units in the new Veterans Hospital to be constructed in Atlanta in the near future. The Chief Medical Officer of the Veterans Administration gave the reason why no intensive therapy unit was planned in the veterans facilities in Atlanta.

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves the report of this Sub-Committee.

HOUSE OF DELEGATES ACTION—Adopted the report of the Hospital Relations Sub-Committee as recommended by the Reference Committee on motion duly made and seconded.

It was moved by the Secretary of Reference Committee No. 2, John B. Morton, Thomasville, and duly seconded that the report of Reference Committee No. 2 be approved as a whole and it was so ordered.

Report of Reference Committee No. 3

I. D. Hellenga, Toccoa, *Chairman*

(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendations and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 3 met in the Rotunda

of the Aquarama, Jekyll Island, Georgia, at 8:00 a.m., May 6, 1963. Members present were: I. D. Hellenga, Toccoa, Chairman; W. L. Pomeroy, Waycross, Vice Chairman; R. C. Davis, Atlanta, Secretary; R. C. McGahee, Augusta; Jack Waldrep, Rome; Waddell Barnes, Macon, and E. D. Wells, Jr., LaGrange.

Eighth District Councilor

F. G. ELDRIDGE, M.D., Valdosta

The Eighth District counselor has attended regular and special meetings and has discharged the duties of his office as required.

Counties and Secretaries	Members December 31, 1962		Members December 31, 1961	
	MAG	AMA	MAG	AMA
Altamaha				
Dan B. Elrod				
Hazlehurst . . .	10	9	10	9
Camden-Charlton				
H. H. Robinson				
Kingsland . . .	8	8	8	8
Coffee				
C. S. Meeks, Jr.				
Douglas . . .	14	7	14	6
Glynn				
J. L. Owens, Jr.				
Brunswick . . .	44	40	44	40
South Georgia				
B. S. Davis				
Valdosta . . .	56	47	56	50
Telfair				
D. B. McRae				
McRae . . .	6	6	8	6
Ware				
S. W. Clark, Jr.				
Waycross . . .	45	36	47	40
Wayne				
D. H. G. Glover				
Jesup . . .	10	8	10	8
	193	161	197	167

F. G. Eldridge
Councilor
Valdosta

REFERENCE COMMITTEE RECOMMENDATION—The Committee recommends acceptance of this report and commends Dr. F. G. Eldridge for his efforts. The Committee also recommends some additional statements as to the activities in his district.

HOUSE OF DELEGATES ACTION—Adopted the report of the Eighth District Councilor as recommended by the Reference Committee and the additional recommendation of the Reference Committee on motion duly made and seconded.

Eighth District Vice Councilor

J. W. YEOMANS, M.D., Jesup

There is a special problem in one location in the Eighth District which involves the corporate practice of medicine by a hospital, fee splitting between a radiologist and the hospital, and extreme intrusion of a

hospital governing board into the field of the practice of medicine. A radiologist with twelve years experience in the community, although supported by the medical staff, faces a loss of 40 to 50 per cent of his professional income to the hospital or replacement by another radiologist who the hospital authority threatens to bring in. Although this immediate problem concerns radiology, the anesthesiologists and pathologists face the same problem. If the governing board succeeds in carrying out their threat this represents an extremely dangerous situation locally and this involves not only the local situation but will involve these specialties in the entire state. The only service rendered by the hospital to the radiologist which is not rendered to all the other members of the medical staff is to collect his professional fee. It is recommended that the Medical Association of Georgia look into this matter and take appropriate action. Complete details can be furnished.

REFERENCE COMMITTEE RECOMMENDATION—The Committee noted this report with interest. The Committee was informed that Dr. J. W. Yeomans' recommendation that MAG investigate this situation is being carried out. The Committee further recommends that Council continue to investigate similar situations that may exist throughout the state and endeavor to establish an overall policy to cover both.

HOUSE OF DELEGATES ACTION—Adopted the recommendation of the Reference Committee pertinent to the report of the Eighth District Vice Councilor and the additional recommendation on this matter made by the Reference Committee on motion duly made and seconded.

Governmental Medical Services

LUTHER H. WOLFF, M.D., Chairman

The Board of Governmental Medicine did not have a formal meeting during the year 1962-1963. However, the several Sub-Committees were mostly active in the various assigned areas of endeavor and their reports which follow actually constitute the real work of this Board.

The Chairman of the Board wishes to take this opportunity to thank the Chairmen of the Sub-Committees and also all members of Sub-Committees for their activities and cooperation.

Crippled Children Sub-Committee

E. B. DUNLAP, JR., M.D., Chairman

I am in receipt of your letter of March 12, 1963, regarding my report as "Chairman of the Sub-Committee on Crippled Children." It is an oversight that such has not been received by you and for such I apologize.

There has been no activity of this Sub-Committee throughout the past year.

I trust this information is that which you desire.

REFERENCE COMMITTEE RECOMMENDATION—It was apparent to your Reference Committee that this Board and Sub-Committee have not met formally during the past year. It is the Committee's feeling and recommendation that this Board and Sub-Committee are of such importance that formal meetings should have been held and reports of such made available.

HOUSE OF DELEGATES ACTION—Adapted the recommendation of the Sub-Committee pertinent to the reports of the Governmental Medical Services Board and the Sub-Committee on Crippled Children.

Disaster Medical Care Sub-Committee

VIRGIL B. WILLIAMS, M.D., *Chairman*

During the past year this committee has worked in close harmony with the State Health Department and the State Civil Defense organization.

Excellent liaison between these organizations and this committee exist at this time. In November members of this committee attended in Chicago a conference on disaster medical care sponsored by the Council on National Security.

In February members of this committee attended and took part in a conference on Disaster Medical Care sponsored by the American Medical Association at the Biltmore Hotel in Atlanta. At this meeting the Chairman gave a report outlining progress and plans for Disaster Medical Care for the State of Georgia.

As requested by this committee the Georgia Department of Public Health is at this time constructing a building in which will be housed a Civil Defense Emergency Hospital which is to be used for training and instruction purposes. It is anticipated that this Civil Defense Hospital Unit will be utilized by physicians, nurses, civil defense and all interested ancillary personnel. At the present time plans for an alert system which will reach all doctors in the state are being formulated.

This committee wishes to thank the Georgia Department of Public Health and the Georgia Department of Civil Defense for its cooperation during the past year.

REFERENCE COMMITTEE RECOMMENDATION—The Chairman, Dr. Virgil B. Williams, is commended for his report and the Reference Committee urges acceptance of this report. It is also urged that this Sub-Committee continue to pursue the plans as outlined in this report. The Reference Committee further urges that all county medical societies and medical staffs implement Civil Defense Programs.

HOUSE OF DELEGATES ACTION—Adopted this report of the Disaster Medical Care Sub-Committee as recommended by the Reference Committee and the additional recommendation of the Reference Committee on motion duly made and seconded.

Maternal and Infant Welfare Sub-Committee

EUGENE L. GRIFFIN, M.D., *Chairman*

Maternal Section

Under the chairmanship of Doctor Eugene Griffin, the Maternal Section held at least six or seven meetings in 1962-63. Another meeting is scheduled previous to the annual meeting. Five of the meetings will have been case-review meetings, and three concerned with legislation related to sterilization.

Due to the death of Doctor Howell Wasden, a new committee member was appointed, Doctor J. T. Smith of Manchester.

The Maternal Section is happy to report that their work load in relation to the maternal deaths continues to decrease in numbers and rate annually.

Review of tabulations for 1959 and 1961 reveals that the number decrease was from 69 to 52, and rate per 10,000 live births from 8.9 to 5.2. This decrease was significant in the non-white group, 18.4 to 9.1. Toxemias were ascribed as the cause of only eight deaths in 1961, as against 18 in 1959. Hemorrhage was by far the leading single cause of death in 1961, eleven of these attributed to ruptured uteri, three to ectopic pregnancies. The 9,177 births without a physician in attendance is still a matter of concern, representing

25.4 per cent of the non-white live births.

Projects of the Committee still in discussion phase are: 1) toxemia, a simple directive as to management; 2) review of cases by groups by cause, for publication in the *Journal*, including version and extraction deaths, toxemias and abortions, and for panel discussions at district meetings; and 3) sterilization legislation.

The matter of legislation related to sterilization was referred to the Committee and given considerable time at three separate meetings. This action was precipitated by the fact that the 1937 eugenics law is no longer considered tenable by the State Health Department, with some good reasons, and by the fact that a number of physicians on the Committee, and over the State, are concerned over the legality of "voluntary sterilization" procedures. No agreement was ever reached as to next steps. In view of the fact that this item came to the Committee rather late in the year, and very soon before 1963 Legislature, and that the Committee could not reach agreement as to what would be most desirable for all concerned, Doctor Griffin deferred action until 1963-64.

Perinatal Section

Under the leadership of Dr. Eugene Griffin and Dr. William Laupus, this group sponsored a study of fetal and neonatal deaths of infants weighing at birth between two pounds, one ounce, and five pounds, eight ounces (1,000-2,500 grams). These were selected on a sampling basis. The sampling and preparation of questionnaires and letters and querying the individual physicians was collaborative effort of the Medical Association of Georgia and the Georgia Department of Public Health, coordinated by Dr. Lillian Warnick. Physician cooperation has been excellent, and appreciation is hereby expressed.

At the date of this writing, January 22, 1963, 107 queries have been sent on fetal deaths, and 96 on neonatal deaths. In the process of three of the four day-long meetings held as planned during the year, 49 fetal death cases were completed and reviewed, and 41 neonatal cases.

Although the questionnaire provided information of less specific nature than the Committee had hoped, the Committee selected the most likely cause of death on the basis of the available information. The tabulation below contrasts the major diagnosis obtained from the death certificate with that chosen by the Committee in the 41 neonatal deaths of premature infants thus far reviewed:

CAUSE OF DEATH GIVEN ON DEATH CERTIFICATE

Anoxia	0
Atelectasis	13
Erythroblastosis	1
Hyaline Membrane Disease	4
Pneumonia	2
Prematurity	16
Respiratory Distress Syndrome	1
Unknown	1
Other	3
TOTAL	41

CAUSE OF DEATH IN COMMITTEE'S OPINION

Anoxia	2
Atelectasis	2
Erythroblastosis	1
Hyaline Membrane Disease	0
Pneumonia	1
Prematurity	0
Respiratory Distress Syndrome	28
Unknown	2
Other	4
TOTAL	40

In 31 instances Committee opinion favored a respiratory cause for death, utilizing the term "respiratory distress syndrome" for 28. The Committee's reclassification added to this category 11 infants who were not so included from death certificate information and reclassified others from atelectasis, pneumonia and hyaline membrane disease. Autopsy confirmation of death was lacking in most instances and the diagnosis of respiratory distress syndrome seemed more appropriate than undocumented atelectasis, aspiration of amniotic fluid, hyaline membrane disease or pneumonia, all being included in the larger category.

The study confirms the importance of respiratory problems in neonatal death among the prematurely born and suggests that there is little agreement among the physicians submitting the questionnaires as to the specific clinical respiratory problem responsible for death. Greater utilization of a broad diagnostic term, such as respiratory distress syndrome, might be helpful in providing a diagnostic area where respiratory problems which are not clearly defined could be assigned. The premature death rate, so dependent as it is upon respiratory causes, will not be reduced appreciably until further research leads to more specific preventative and therapeutic measures for these various respiratory ailments.

As far as fetal deaths were concerned, the Committee assigned nine to abruptio placenta, as against one assigned by the physician. Twenty of the 49 were assigned as "other or unknown" by the physician, as against 23 by the Committee.

There were nine autopsies in the total 90 cases, two on fetal deaths and seven on neonatal deaths.

In the coming year at least four meetings will be held, the first to review the past year's work, and to plan the next steps on the basis of this review.

REFERENCE COMMITTEE RECOMMENDATION—Maternal Section: The Reference Committee urges acceptance of this report and highly commends Dr. Eugene Griffin, Chairman, and his Sub-Committee for their activities and report. It further recommends that statistics showing the decrease in maternal death rate be given public dissemination by press release. Perinatal Section: The Reference Committee recommends acceptance of this report and highly commends this excellent and detailed study by Dr. Griffin, Dr. Laupus, et al, and strongly urges that greater efforts be made to obtain autopsies to more accurately ascertain causes of fetal and neonatal deaths .

HOUSE OF DELEGATES ACTION—Adopted the report of the Maternal Infant Welfare Sub-Committee as recommended by the Reference Committee and the additional recommendation of the Reference Committee on motion duly made and seconded.

Public Health Sub-Committee

R. W. EDENFIELD, M.D., *Chairman*

The chairman of this committee has kept in touch with the public health program in the state and feels that it is serving the community satisfactorily. No specific problems on issues have been brought to our attention. The committee plans to keep in touch with the public health program and to advise and suggest to the State Health Department as specific issues come up.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee recommends acceptance of R. W. Edenfield's report and commends him for his activities.

HOUSE OF DELEGATES ACTION—Adopted the report of the Public Health Sub-Committee as recommended by the Reference Committee on motion duly made and seconded.

Finance

J. G. McDANIEL, M.D., *Chairman, Atlanta*

The Finance Committee met on November 18, 1962 and proposed the following budget for the Medical Association of Georgia: It was approved by the Council on December 8, 1962.

Other members of the Committee are Doctor Virgil Williams and Doctor Charlie Andrews.

INCOME

	1962 Budget	Actual Jan. 1-Nov. 30, '62	1963 Budget
I. (a) MAG Dues	\$102,000.00	\$105,655.00	\$105,000.00
(b) Int. & AMA	1,200.00	2,505.92	2,000.00
(c) GP Service	3,250.00	2,979.13	3,250.00
(d) Funds Carr. 1961	11,819.96	11,819.96	—
II. Annual Session	8,225.00	8,175.00	8,750.00
III. Journal	38,000.00	28,717.71	41,000.00
Total Income	\$164,494.96	\$159,852.72	\$160,000.00

EXPENSES

I. (a) Fixed Allot.	\$ 13,450.00	\$ 6,590.59	\$ 13,625.00
(b) Assoc. Office	68,450.89	56,144.10	72,903.39
(c) Assoc. Boards	20,745.00	13,275.59	21,005.00

(d) Related MAG Act.	1,400.00	1,158.46	1,300.00
(e) Cont. Fund	15,897.87	6,432.72	4,126.61
II. Journal	44,551.20	37,498.33	47,040.00
Total Expenses	<u>\$164,494.96</u>	<u>\$121,099.79</u>	<u>\$160,000.00</u>

I. (a) FIXED ALLOTMENTS

Payment on Mort.	\$ 4,000.00	—	\$ 4,000.00
Int. on Mort.	1,350.00	—	1,150.00
MAG Atty. Ret.	2,400.00	\$ 1,800.00	2,400.00
MAG Atty. Expenses	300.00	140.59	300.00
Woman's Aux.	1,500.00	1,500.00	1,875.00
Pension Payments	2,400.00	1,650.00	2,400.00
Pres. Honorarium	1,000.00	1,000.00	1,000.00
Annual Audit	500.00	500.00	500.00
(A) Sub-Total	<u>\$ 13,450.00</u>	<u>\$ 6,590.59</u>	<u>\$ 13,625.00</u>

(b) ASSOCIATION OFFICE

Salaries	\$ 38,920.00	\$ 35,203.24	\$ 40,340.00
Bonus	1,925.41	—	2,327.50
Ins. and Bonds	1,000.00	1,060.72	1,585.89
Payroll Taxes	1,705.48	1,179.11	1,500.00
Travel:			
Office	4,000.00	3,396.76	4,000.00
Del. Sec. to AMA			
Annual and Clinic	2,000.00	1,750.00	3,000.00
Alt. Del.	—	—	1,200.00
Main. and Repair:			
Building	750.00	443.37	750.00
Equipment	750.00	359.58	750.00
Tel. and Tel.	4,000.00	4,050.64	4,000.00
Depreciation:			
Building	2,000.00	—	2,000.00
Equipment	650.00	—	650.00
Postage	3,000.00	2,128.73	3,000.00
Office Supplies	2,750.00	2,474.38	2,750.00
Jan. Serv. and Grat.	1,450.00	1,318.00	1,550.00
Meetings	800.00	545.51	800.00
Dues and Sub.	250.00	250.00	300.00
Heat, Lights, Water	2,100.00	1,805.09	2,100.00
Sundry	400.00	178.97	300.00
(B) Sub-Total	<u>\$ 68,450.89</u>	<u>\$ 56,144.10</u>	<u>\$ 72,903.39</u>

(c) ASSOCIATION BOARDS

	1962 Budget	Actual Jan. 1-Nov. 30, '62	1963 Budget
1. Annual Session	\$ 8,525.00	\$ 7,294.73	\$ 9,300.00
2. Constitution and Bylaws	—	—	—
3. Hospital Activities			
a. Blood Banks	100.00	60.00	175.00
b. Hospital Rel.	50.00	—	100.00
4. Governmental Med. Sev.	100.00	—	—
a. Crippled Child.	—	—	—
b. Dis. Med. Care	200.00	—	200.00
c. Mat. and Inf. Wel.	305.00	156.63	500.00
d. Pub. Hlt.	100.00	—	—
e. Rehabilitation	—	—	—
f. Sch. Cld. Hlt.	1,650.00	277.76	1,925.00
g. Vet. Affairs	150.00	—	50.00
5. Ins. and Econs.	900.00	242.18	1,000.00
a. Rel. Val. Std.	840.00	—	800.00
6. Interprof. Rel.	125.00	125.00	125.00
7. Legislation	2,500.00	2,500.00	2,425.00
a. Nat. Leg.	—	—	—
b. State Leg.	—	—	—

8. <i>Med. Education</i>	—	—	—
a. AMA-ERF	—	—	25.00
b. Clks. Labs.	—	—	—
c. Med. Ed.	200.00	—	—
d. Med. Sch. C.	—	—	—
9. <i>Occup. Health</i>	400.00	—	—
a. Ind. Hlt.	—	—	—
b. Rul. Hlt.	100.00	—	—
10. <i>Public Service</i>	1,800.00	1,085.34	2,000.00
a. Public Ser.	—	—	—
b. Wky. Hlt. Clm.	2,000.00	1,413.03	1,730.00
11. <i>Special Acct.</i>	—	—	—
a. Hlt. Care Ag.	400.00	120.92	500.00
12. <i>Vol. Hlt. Agencies</i>	—	—	—
a. Cancer	—	—	150.00
b. Mental Hlt.	—	—	—
(C) Assoc. Bds. Total	\$ 20,745.00	\$ 13,275.59	\$ 21,005.00

(d) REL. MAG. ACTIVITIES

AMA Del. Meet.	\$ 400.00	\$ 266.92	\$ 400.00
Med. Defense	300.00	300.00	300.00
Phy. Law Liaison	50.00	—	—
Prof. Conduct	50.00	17.44	—
SAMA	500.00	500.00	500.00
AMEB	100.00	74.10	100.00
(D) Sub-Total	\$ 1,400.00	\$ 1,158.46	\$ 1,300.00

(e) CONTINGENT FUND

1962—Cont.	\$ 4,077.91	—	—
1961—Cont. Unapp.	4,626.30	—	—
1961—Pres. Hon.	500.00	\$ 500.00	—
1961—Med. Def.	167.25	167.25	—
1961—Mer. Harris, Atty.	3,500.00	3,500.00	—
1961—File MAA	91.77	91.77	—
1961—Allied Med Car.	50.00	50.00	—
1961—Elec. Typewrit.	501.40	501.40	—
1961—JMAG Cpyrgt.	100.00	100.00	—
1961—Prof. Cond.	300.00	100.00	—
1961—SE States Hosp.	300.00	251.41	—
1961—Legislation	700.00	187.65	—
1961—Dues and Sub.	61.39	61.39	—
1961—Kitchen	921.85	921.85	—
Sub-Total	\$15,897.87	\$ 6,432.72	—

II. JOURNAL

Expenses:

Printing	\$ 32,000.00	\$ 26,740.00	\$ 35,000.00
Salaries (3)	5,760.00	6,061.07	7,020.00
Bonus	585.00	—	605.00
Ins.	136.20	163.17	160.00
Payroll Taxes	350.00	239.05	355.00
Engr. and Cuts	2,400.00	1,479.85	1,500.00
Sales Tax	960.00	802.20	1,050.00
Postage	500.00	500.00	500.00
Stationery	500.00	441.25	300.00
Clipping Ser.	250.00	208.45	250.00
Add. and Sup.	250.00	165.88	250.00
Editorial Asst.	250.00	100.00	(Inc. in salaries)
Meetings	550.00	560.24	—
Sundry	60.00	37.17	50.00
TOTAL	\$ 44,551.20	\$ 37,498.33	\$ 47,040.00

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee recommends acceptance and commends the Chairman, J. D. McDaniel, for his activities. It also recommends approval of the 1963 budget by the House of Delegates.

HOUSE OF DELEGATES ACTION—Adopted the report of the Finance Committee as recommended by the Reference Committee on motion duly made and seconded.

Professional Conduct Committee

H. D. ALLEN, JR., *Chairman*

There has been only one matter under consideration, a complaint from a patient against two Atlanta doctors. This came as an appeal from the patient after the Fulton County Medical Society had acted upon this, and as the Professional Conduct Committee did not have any transcript of information leading to the decision of the Fulton County Medical Society, it was referred back to the Medical Society for any statements they had received from the patient and any answers they had had from the physicians involved. All correspondence has been circulated to all members of the Committee and a meeting of this Committee will not be held until the regular Medical Association of Georgia convention at Jekyll Island in May.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee recommends the acceptance of Dr. H. D. Allen's report and commends him for his efforts.

HOUSE OF DELEGATES ACTION—Adopted the report of the Professional Conduct Committee as recommended by the Reference Committee on motion duly made and seconded.

Woman's Auxiliary Advisory

DR. RALPH W. FOWLER, SR., *Chairman*

The Woman's Auxiliary Advisory Committee attended the summer board meeting of the Executive Board of the Woman's Auxiliary in July, 1962, at Americus. After hearing all the program plans of the various state officers and chairmen, the committee concurred and heartily endorsed the plans for the forthcoming year. In the evening, a sumptuous dinner was served by Dr. and Mrs. Ennis W. Waldemayer at their charming antebellum home.

The members of the Advisory Committee have been available for consultation throughout the year.

The regular mid-winter meeting was held in the headquarters building in Atlanta, Georgia, January 18th. In addition to the Advisory Committee, ex-officio member Dr. Thomas W. Goodwin, President of the Medical Association of Georgia, was present. He commended the auxiliary members on their good work and pledged the support of MAG to the Woman's Auxiliary.

Having a ringside seat to the encompassing activities of the Woman's Auxiliary has been a rewarding, broadening, and enjoyable experience to this committee.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee approves and commends this report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Woman's Auxiliary Advisory Committee when the Reference Committee report as a whole was adopted.

Sixth District Councilor

WILLIAM RAWLINGS, M.D., *Sandersville*

It has again been quite an honor and privilege to serve as your Councilor for the Sixth District this year. I have been able to attend all regular Council meetings except one that was held in Albany and had the privilege of attending the annual County Society Officers meeting which was held at the Dinkler Plaza in Atlanta in early March, 1963. The attendance from our local

society at this meeting, which was an excellent presentation, was not as good as expected but the attendance was cut down because of the influenza epidemic which occurred at that time.

The Sixth District Medical Society had its fall meeting in Macon with an excellent scientific program being presented and good attendance. The scientific session was followed by a delightful social hour. All information and requests that have come down from MAG and from Council have been transmitted on to societies wherever indicated.

The program that was offered at the County Society Officers meeting at the Dinkler Plaza stressed physical fitness and politics in medicine. This was an excellent program and information gained from this has been transmitted to local membership throughout the Sixth District. We are again facing a political problem and the entire membership of this District is being urged to cooperate in every way possible in order to maintain the position of medicine at this time.

Attached is a list of the Sixth District membership and it is again hoped that the AMA membership will continue to rise as the years go by.

Counties and Secretaries	Members December 31, 1962		Members December 31, 1961	
	MAG	AMA	MAG	AMA
Baldwin				
George L. Echols, Jr.				
Milledgeville . . .	33	23	33	16
Jasper				
E. M. Lancaster				
Shady Dale . . .	3	3	3	3
Jefferson				
John J. Pilcher				
Wrens	7	5	7	5
Laurens				
Nelson Carswell				
Dublin	28	14	30	15
Washington				
L. R. Harvey				
Sandersville . . .	12	1	11	1
	83	46	84	40
William Rawlings				
Councilor				
Sandersville				

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee approves and commends this report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Sixth District Councilor when the Reference Committee report as a whole was adopted.

Bibb County Councilor

GEORGE H. ALEXANDER, M.D., *Forsyth*

Most of the activities of the Bibb County Medical Society Councilor are reported in the Report of Council by the Chairman of Council. By virtue of being Chairman of Council, I have been on Executive Committee and have attended all of the regular meetings of Council and Executive Committee, as well as participating in the called telephone conference meetings of Executive Committee.

The Bibb County Medical Society has had a good year. At the December meeting of the Bibb County Medical Society, Braswell Collins was named President-Elect and John T. DuPree was re-elected as Secretary. George H. Alexander was nominated to the Medical Association of Georgia by the Society for another three-year term as Councilor to begin following the annual meeting of the Medical Association of Georgia in May, and W. H. M. Weaver was nominated as Vice Councilor.

The Bibb County Medical Society has met regularly and has enjoyed good scientific programs.

The following is a report on the membership figures for December 31, 1962 and December 31, 1961:

Counties and Secretaries	Members December 31, 1962		Members December 31, 1961	
	MAG	AMA	MAG	AMA
Bibb				
John T. DuPree				
Macon	169	152	152	138

George H. Alexander
Councilor
Forsyth

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee approves and commends this report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Bibb County Councilor when the Reference Committee report as a whole was adopted.

Resolution No. 1

GUBERNATORIAL APPOINTMENTS TO STATE BOARDS

JOHN B. O'NEAL FOR ELBERT-FRANKLIN-HART
MEDICAL SOCIETY

Be it resolved, that any appointments made by the Governor of the State of Georgia to such posts as the Medical Examining Board of the State of Georgia be first approved by The Medical Association of Georgia and by the appointee's County Medical Society.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee considered the Resolution as presented and recommends modification to read as follows:

"WHEREAS, the relations between the Medical Association of Georgia and the State Board of Medical Examiners are good, and

"WHEREAS, these continued good relations depend on harmony between this Association and the Governor of the State of Georgia regarding appointments to the State Board of Medical Examiners and to other State Boards with responsibilities for the health care of the citizens of Georgia,

"NOW THEREFORE, BE IT RESOLVED, that the House of Delegates of the Medical Association of Georgia respectfully requests liaison between the Governor and this Association regarding appointments to the State Board of Medical Examiners and to other State Boards with responsibilities for the health care of the citizens of Georgia."

HOUSE OF DELEGATES ACTION — Adopted Resolution No. 1: Gubernatorial Appointments to the Board of Medical Examiners, etc. as amended by the Reference Committee on motion duly made and seconded.

It was moved by Chairman of the Reference Committee No. 3, I. D. Hellenaga, Toccoa, and duly sec-

onded that the report of Reference Committee No. 3 be approved as a whole and it was so ordered.

Report of Reference Committee No. 4

William Moore, Atlanta, Chairman

(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 4 met in the Rotunda of the Aquarama, Jekyll Island, Georgia, at 2:30 p.m., May 6, 1963. Members present were: William Moore, Atlanta, Chairman; Robert Coggins, Marietta, Vice Chairman; C. J. Roper, Jasper, Secretary; Van B. Bennett, Valdosta; R. J. Moye, Swainsboro, and E. C. McMillan, Macon.

Seventh District Councilor

RALPH N. JOHNSON, M.D., Rome

The Seventh District Medical Society completed a very active and successful year. The spring meeting which was held in Rome and the fall meeting which met in Summerville were well attended and the scientific papers presented were interesting.

Several new doctors have elected the Seventh District area of Georgia to practice the healing art. Seven of these men selected Rome as their new home.

The doctors in this area have been informed of GaMPAC and its importance to the future practice of medicine.

Many of the doctors have worked vigorously in letting our Senators and Congressman know how we feel about the King-Anderson bill and our Congressman assured us that he is with us.

We are looking forward to a great year in 1963.

Counties and Secretaries	Members December 31, 1962		Members December 31, 1961	
	MAG	AMA	MAG	AMA
Bartow				
Virginia D. Hamilton				
Cartersville . . .	8	7	8	7
Carroll-Douglas-Haralson				
J. H. Beall				
Carrollton . . .	35	30	35	29
Chattooga				
J. A. Stewart				
Summerville . . .	8	8	6	6
Cobb				
Robert D. Mainor				
Smyrna	83	78	84	78
Floyd				
Cliff Moore				
Rome	66	58	58	53
Gordon				
J. LeRoy Rabb				
Calhoun	9	8	9	8
Polk				

A. B. Campbelle				
Cedartown . . .	14	12	14	11
Walker-Catoosa-Dade				
M. K. Cureton				
LaFayette . . .	34	26	32	23
Whitfield				
Fort F. Felker				
Dalton	35	27	33	24
	<u>292</u>	<u>254</u>	<u>279</u>	<u>239</u>

Ralph N. Johnson
Councilor
Rome

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee approves and commends the report of the Seventh District Councilor.

HOUSE OF DELEGATES ACTION—Adopted the report of the Seventh District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Ninth District Councilor

CHARLES R. ANDREWS, JR., M.D., *Canton*

During the past year Ninth District has been represented at all the regular and called meetings of Council by the Councilor and Vice Councilor.

The Ninth District continues to be a strong and active District holding two excellent meetings in April and September of each year. It will be noted below on the breakdown that the MAG and AMA members are essentially the same with a few variations from the 1961 report.

It has been a pleasure to have served as Ninth District Councilor and I am happy to report that the Ninth District remains one of the stronger Districts in the State.

Counties and Secretaries	Members December 31, 1962		Members December 31, 1961	
	MAG	AMA	MAG	AMA
Blue Ridge				
Thomas J. Hicks				
McCaysville . . .	10	6	10	6
Chattahoochee				
Cecil L. Miller				
Buford	20	16	20	16
Cherokee-Pickens				
John A. Cauble				
Canton	13	11	13	11
Habersham				
Jack B. Edwards, Jr.				
Cornelia	15	13	18	15
Hall				
Clark Ferrell				
Gainesville . . .	53	48	51	48
Jackson-Barrow				
A. A. Rogers, Jr.				
Commerce . . .	17	12	18	13
Rabun				
John T. Norman				
Clayton	3	2	3	2
Stephens				

Irving D. Hellenga				
Toccoa	18	14	17	15
	<u>149</u>	<u>122</u>	<u>150</u>	<u>126</u>

C. R. Andrews
Councilor
Canton

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee approves and commends the report of the Ninth District Councilor.

HOUSE OF DELEGATES ACTION—Adopted the report of the Ninth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Tenth District Councilor

A. W. SIMPSON, JR., M.D., *Washington*

I wish to report a most successful year for the Tenth District. All component societies have been active. The Tenth District Society held two meetings, the summer meeting with the Oconee Valley Society, and the winter meeting with the Richmond County Society. The scientific programs were excellent but attendance was very poor.

I would like to suggest that the Councilor from each District be made responsible for the District Society Meeting, and in this way these societies may be better coordinated with the Medical Association of Georgia and with the component county societies, with the more active participation of the individual doctors being the prime target of the Councilors' efforts.

I would like to thank Dr. Marion Hubert, Vice Councilor for the Tenth District, for taking over so well while I was incapacitated.

Counties and Secretaries	Members December 31, 1962		Members December 31, 1961	
	MAG	AMA	MAG	AMA
Crawford W. Long				
George Erwin				
Athens	53	41	51	42
Elbert-Franklin-Hart				
C. A. Mickel, Jr.				
Elberton	22	17	22	16
McDuffie				
John W. Lemley				
Thomson	8	7	6	6
Oconee Valley				
L. K. Lewis				
Madison	13	8	12	8
Walton				
R. E. Wenzel				
Monroe	9	8	10	9
Warren				
H. B. Cason				
Warrenton . . .	1	—	2	—
Wilkes				
Henry C. Standard, Jr.				
Washington . . .	9	6	11	8
	<u>115</u>	<u>87</u>	<u>114</u>	<u>89</u>
Addison Simpson, Jr.				
Councilor				
Washington				

REFERENCE COMMITTEE RECOMMENDATION—Reference Committee accepts and approves the report of the Tenth District Councilor with the following substitution deleting Paragraph 2: The Reference Committee suggests that the District Councilors work with the District Medical Society Officers in the preparation of the District Scientific Programs.

HOUSE OF DELEGATES ACTION—Adopted the report of the Tenth District Councilor as recommended by the Reference Committee including the Reference Committee revision of Paragraph 2 of said report on motion duly made and seconded.

Richmond County Councilor

HARRY D. PINSON, M.D., *Augusta*

As Councilor of the Richmond County Medical Society to the Medical Association of Georgia, I have attended all Council meetings of the past year. I have made periodic reports to my County Medical Society and transmitted all important business as instructed by Council. I have served as Chairman of the Sub-Committee on Relative Value Study.

I would like to urge the House of Delegates and Council to again stress the importance of all members of the Medical Association of Georgia taking part in contacting our legislators in regard to any legislation that is of importance to the medical profession. It has been my observation that although the House of Delegates passed a resolution requesting increased participation in this matter that the great majority of the doctors depend on the officers of the Association to do this for them. I think it is of utmost importance for all physicians to take part in this.

I think the past year has been a very successful one for the Medical Association of Georgia and I look forward to further advances in our Society's work.

Counties and Secretaries	Members December 31, 1962		Members December 31, 1961	
	MAG	AMA	MAG	AMA
Richmond				
Henry D. Scoggins				
Augusta	243	204	230	201
H. D. Pinson				
Councilor				
Augusta				

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee accepts and commends the report of the Richmond County Medical Society Councilor.

HOUSE OF DELEGATES ACTION—Adopted the report of the Richmond County Medical Society Councilor as recommended by the Reference Committee on motion duly made and seconded.

Richmond County Vice Councilor

J. L. MULHERIN, M.D., *Augusta*

As Vice Councilor from the Richmond County Medical Society, it has been my pleasure during the past year to have attended all the Council meetings at various cities throughout the state.

I have been very much impressed by the efficient manner in which Council conducts its vast volume of business. Although I did not have a vote in any of the decisions since our Councilor also attended all the meet-

ings, I enjoyed the discussions of the various problems at the meetings and look forward to attending future meetings of Council.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee accepts and commends the report of the Richmond County Medical Society Vice Councilor.

HOUSE OF DELEGATES ACTION—Adopted the report of the Richmond County Medical Society Vice Councilor as recommended by the Reference Committee on motion duly made and seconded.

Council of MAG

GEORGE H. ALEXANDER, M.D., *Chairman*

The year 1962-63 has been another eventful and busy year for the Council and Headquarters Staff of MAG.

At the outset of this report, I, as Chairman of Council, would like to thank all the officers, members of Council, the committees and the headquarters staff for the fine work and cooperation which you have so wholeheartedly given. Without this, the story would be quite different.

Special commendation is due our Treasurer and the Finance Committee for the fine financial report which will be presented to you. Consideration might have been given to a substantial prepayment on the building loan, but it was felt wise to wait until we could know what our final liability in legal fees and taxes might be.

It is felt that it would be helpful in this report to review the Minutes of Council and Executive Committee and give a brief resume of important actions taken by Council. For full information on the following, as well as other actions, the full Minutes of Council and Executive Committee may be referred to.

May 9, 1962

At this organizational meeting of Council, George H. Alexander was elected Chairman and Virgil Williams was elected Vice Chairman. Edgar Woody was reappointed as Editor of The Journal of MAG. J. G. McDaniel was appointed Chairman of the Finance Committee with Charles Andrews and Virgil Williams as the other members. John Atwater was elected Treasurer. Mr. Milton D. Krueger was reappointed as Executive Secretary.

June 16, 1962

Approved a resolution on the untimely death of former Secretary Chris McLaughlin in the Paris plane crash.

Approved the expansion of Kerr-Mills to include aid to the blind and aid to the totally and permanently disabled. Authorized Dr. Mauldin to assume the advisory functions and processing of claims.

Approved the Mercer Resolution which resolved the differences between the different Blue Shield groups in their plans to offer the Senior Citizens Policy.

July 2, 1962

Executive Committee phone conference meeting. Dr. Goodwin reported that a suit had been filed in Federal Court against MAG for the purpose of altering our membership requirements. Our attorneys were au-

thorized to file motion to have suit dismissed and if motion denied to request a summary judgment from the bench.

July 18, 1962

Executive Committee authorized MAG attorneys to file suit to enjoin tax officials of Fulton County and City of Atlanta from levying to collect property taxes from MAG.

September 8-9, 1962

Council approved Executive Committee recommendation for changes in proposed recodification of health laws to provide:

1. That the Director of the State Health Department not be under the Merit System.
2. That the full State Board of Health meet monthly.

It was further recommended that the MAG take renewed interest in subsequent nominations to the Board of Health.

Approved in principle a family responsibility bill, but opposed any version which would constitute practice of medicine by the State.

November 4, 1962

Executive Committee approved new Rules and Regulations regarding Medicare Review Boards.

Executive Committee held an informal conference with James L. Bentley, the Comptroller General-Elect, regarding liaison on Health Insurance matters.

December 8-9, 1962

Council approved proposal concerning Family Responsibility bill whereby physicians in state institutions would contract to set up professional associations, and the State would render bill to include per diem fee for professional services which would be donated for research and training purposes.

Council approved the Association proposed budget as submitted by the Finance Committee for the calendar year 1963.

Council considered proposed changes in the MAG Constitution and Bylaws and made recommendations regarding these proposed changes. These recommendations appear in *italic* at the conclusion of the report of the Constitution and Bylaws Board.

Council approved a report and its recommendations by President Goodwin concerning a meeting of Executive Committee with the State Board of Medical Examiners and a later meeting between President Goodwin and Chairman Savage of the State Board, Mr. Krueger and Mr. Clifton, Secretary of the State Examining Board. At this last meeting recommendations for better understanding and maintenance of good liaison were worked out.

Requested the Insurance and Economics Board to continue investigation as to the best means to set up a retirement plan under H.R. 10 (Self Employed Retirement Act) and that investigation not be limited to any one source of advice and counsel at the present time.

January 19, 1963

Executive Committee approved a new Mental Health Sub-Committee with one representative from each Congressional District, and Addison M. Duval, the

new Director of the Division of Mental Health of the State Health Department as an ex-officio member.

Executive Committee approved a change in the Medicare contract whereby the same fee will be paid for new born care to the M.D. delivering as would be paid another M.D. called in to provide such new born care.

Dr. Simonton reported that the "Family Responsibility" bill as approved by MAG had been written into the bill to recodify the public health laws. Also that all the changes suggested by MAG had been written into the bill.

March 23-24, 1963

It was reported that the civil suit in Federal court against MAG for the purpose of alternating our membership requirements was dismissed.

Council approved a revised Workman's Compensation Fee Schedule which had been previously approved by the State Board of Workman's Compensation.

On recommendation of Executive Committee of Council, the Council approved the promotion of Mrs. Catherine Wooten from the MAG Headquarters Office Staff position of Executive Assistant to Assistant Executive Secretary.

Council voted to approve the President's recommendation for study by Council on the advisability of redistricting the State as regards the District Medical Societies and also to consider the possible consolidation of some smaller County Medical Societies to strengthen them. He recommended such study report be submitted to the 1964 House of Delegates.

Reports of the individual Councilors and Vice Councilors follow.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee accepts and commends the report of Council of MAG.

HOUSE OF DELEGATES ACTION—Adopted the report of the Council of MAG as recommended by the Reference Committee on motion duly made and seconded.

Constitution and Bylaws

W. G. ELLIOTT, M.D., *Chairman*

The Board of Constitution and Bylaws of the Medical Association had three questions submitted for study and clarification.

1. The Medical Association of Georgia House of Delegates referred the question of making the First Vice President a voting member of the Executive Committee of Council.
2. Medical Defense Committee that was left out of the present Constitution and Bylaws, but is referred to in regards to membership in the Medical Association of Georgia.
3. The question of more than two Councilors from a Councilor District.

A meeting of the Constitution and Bylaws Board of the Medical Association of Georgia was held October 26, 1962, at the Headquarters office of the Medical Association of Georgia. Four members of the five member board were present, and also Dr. John Mauldin, Secretary of Medical Association of Georgia, and Mr. Milton Krueger, Executive Secretary of Medical As-

sociation of Georgia. The matter of making the First Vice President a voting member of Executive Committee of Council was discussed, and the Board recommended that the First Vice President be made a voting member of the Executive Committee of Council, and that the Constitution and Bylaws be amended and changed as follows:

Chapter IV, Council, Section 3, Executive Committee: The Council shall organize an Executive Committee at the organizational meeting. The Executive Committee shall be composed of the President, who shall serve as Chairman of the Executive Committee, the President-Elect, the Immediate Past President, the First Vice President, the Secretary, the Chairman of Council, who shall serve as Vice Chairman of the Committee, and the Chairman of the Council Committee on Finance. (Delete the following sentence: The First Vice President shall serve as an Ex-Officio member of the Executive Committee, or in his absence, the Second Vice President.) It was also decided in Chapter V. Election of Officers, Section I, to delete the election of First Vice President, as the Second Vice President now becomes automatically the First Vice President after one year's term of office as Second Vice President. So the new slate of Officers will read: "The President-Elect, the Second Vice President, Secretary, Councilors and Vice Councilors shall be elected by ballot by members of the Association during the Annual Session."

The next item for discussion was the Medical Defense Committee that was left out of the Constitution and Bylaws when the reorganization of the Boards and Committees was made. After much discussion the Board recommends that since the present Constitution and Bylaws carries mention of the privilege of this Committee in the privileges of membership, the following changes be made in the Constitution and Bylaws. Insert the following in the Constitution and Bylaws, as a second paragraph in Chapter X, Section 3 (1) Insurance and Economics—as follows:

"The Insurance and Economics Board shall maintain a Sub-Committee on Medical Defense. The Sub-Committee on Medical Defense shall consist of five members of whom the Chairman of the Committee on Finance and the Secretary shall be members. The other members, one of whom shall be appointed Chairman, shall be appointed by the Executive Committee of Council for terms of five years each. The duties of this Sub-Committee shall be to investigate any claim of alleged malpractice made against any member upon the written request to the Committee by said member. The Committee shall, on advice of Council, in cases deemed worthy of defense, furnish the services of Counsel for the purpose of consultation and advice relative to threatened or actual litigation provided the Association does not assume financial obligation in excess of \$100.00, for any one member in any one calendar year. Any charges or fees in excess of \$100 for any one member in any one calendar year shall be borne by the members so requesting the privilege of Medical Defense consultation and advice as stated herein."

At the Council meeting of the Medical Association of Georgia held December 8-9, 1962, it was voted that there not be more than two Councilors from any one Congressional District, and further voted to refer this to the Constitution and Bylaws Board for study.

The members of the Board of Constitution and Bylaws of Medical Association of Georgia were given the above information by mail, and four of the five members are in agreement with the action of Council. The other member was not heard from. This will call for a change in the Constitution and Bylaws. Chapter IV, Council, Section I, Component County Medical Societies having one hundred or more active members shall be entitled to elect one Councilor and one Vice Councilor directly representing that Society. There shall not be more than two Councilors, and two Vice Councilors from any one Councilor District.

Recommendations of Council

Council voted to refer to the House of Delegates without recommendation, for or against, a proposal approved by the Constitution and Bylaws Board which would provide that the "Medical Defense Committee be reinserted in the Constitution and Bylaws — to be known as the Sub-Committee on Medical Defense."

Voted to refer to the House of Delegates with recommendation for approval the proposal that the First Vice President be made a full voting member of the Executive Committee of Council.

Referred and recommended to the House of Delegates the proposal to amend Chapter V, Section 1 of the Bylaws to delete that portion concerning the election of the First Vice President, since the Second Vice President automatically becomes the First Vice President after serving one year as Second Vice President.

Referred to Constitution and Bylaws Board for study and recommendation a proposal that not more than two Councilors and Vice Councilors be elected from any one Councilor District. At the March 23-24, 1963, meeting of Council it was voted to recommend to the House of Delegates deferral of this proposal in order to give Executive Committee the opportunity to further study this problem and subsequent referral back to the Board of Constitution and Bylaws.

REFERENCE COMMITTEE RECOMMENDATION — (a) The report of the Constitution and Bylaws Board is accepted and commended with the following specific actions concerning the recommendations of Council:

(1) The Committee approves the recommendation proposing that the First Vice President be made a full voting member of the Executive Committee of Council.

(2) The Committee approves the proposal of the Constitution and Bylaws Board providing that the "Medical Defense Committee" be reinserted in the Constitution and Bylaws—to be known as the Sub-Committee on Medical Defense.

(3) The Committee approves the recommendation of Council deferring the proposal to restrict the number of Councilors from any one district until this proposal has been further studied by the Executive Committee and referred back to the Constitution and Bylaws Board.

(4) The Committee approves the recommendation to the House of Delegates the proposal to amend Chapter V, Election of Officers, Section I of the Bylaws to delete that portion concerning the election of the First Vice President, since the Second Vice President automatically becomes the First Vice President after one year's term of office as Second Vice President.

HOUSE OF DELEGATES ACTION—Adopted the recommendations of the Reference Committee in their entirety which were pertinent to the report of the Constitution and Bylaws Board and the recommendations of Council.

Insurance and Economics

DAVID R. THOMAS, JR., M.D., *Chairman*

The work of the Board is essentially unchanged, being primarily concerned with the economics affecting the profession and the insurance for our members and insurance coverage for the public. The liaison with the insurance industry, directly, and through the Health Insurance Council, as represented by the special committee appointed by the Council of the Medical Association of Georgia, has been very satisfactory.

The Georgia Plan

We again call your attention to the fact that the Georgia Plan was established when conditions were such that the socialization of medicine seemed imminent, a number of years ago. We feel that it continues to serve a useful purpose and deserves our support. Dr. John Elliott and Mr. H. B. Collidge of Savannah continue to act as arbitrators and advisors in the handling of claims where there are differences with the participating insurance carriers and the members of our profession. It is surprising the volume of work that goes through on this and the able and efficient manner in which Dr. Elliott and Mr. Collidge handle these difficult and often unappreciated differences. It is recommended that this service be continued and I want to again, in behalf of the Medical Association of Georgia, thank Mr. H. B. Collidge for his valued service.

Continuing of Insurance Coverage for Retired Employees

We recommend very strongly that every effort be made to encourage employees to continue coverage for hospitalization, health and accident, and other medical benefits after retirement.

The Third National Congress on Voluntary Health Insurance in prepayment, as sponsored by the American Medical Association in Chicago February the 15th and 16th, 1963, was attended by your Chairman and Dr. William W. Moore, Jr., representing the Medical Association of Georgia and the Fulton County Medical Society. This Congress was found to be very informative, though no new, startling or outstanding developments were achieved. Such Congresses, we do feel, served a useful purpose in bringing the medical profession, the insurance industry, labor and government representatives together for discussion of socio-economic, voluntary health insurance problems. It might be best expressed, "constantly adapting ourselves to varying needs to various people in changing times." We learned that in 1938, only eight per cent of the population carried voluntary health insurance. Today the coverage is 55 per cent and it is estimated by 1970 that 90 per cent of those aging people, who need or want coverage, will have it on the voluntary plans through either Blue Cross-Blue Shield or the insurance industry.

MAG Group Plans

At a meeting in November of 1962, a representative of the Life Insurance Company of Georgia, who is underwriting our group plans, reported that the participation has remained essentially the same since the inception with 1,191 members being participants on February 8, 1961; on November 10, 1962, there were 1,170 participants, added to this were 13 widows covered by the MH&N plan that has been offered

to them. The overall experience shows a grand total loss ratio of 90.98 per cent, the greatest loss ratio being in the accidental death and disability group, as we had two of our members die during the year who were covered by this type of insurance. The Board feels that greater participation would enable the members of the Medical Association of Georgia to obtain better coverage and that we could appreciate a reduction in premiums with more participation in our group plans. This is being studied by the Board with information to be furnished from men in the insurance industry, who are in a position to advise and compare insurance programs. We hope this will be a benefit to the members of the Medical Association of Georgia.

Self-Employed Individuals Tax Retirement Act of 1962

Though this act was passed in the fall of 1962 and much work has been done, we have as yet to receive final rulings from the Treasury Department and the Federal Securities Administration, the necessary information to complete a basic plan if it is the wish of the members of the Medical Association to sponsor such a plan. We are sure that most of you have been informed and probably misinformed on the available advantages, of which we feel there are many, and the disadvantages which will make it impossible for many of our members to participate.

It is anticipated that a questionnaire will be sent to each member prior to the next meeting of the House of Delegates and it is hoped that an addendum to this report will give us some information as to the possibility of the Medical Association of Georgia sponsoring and forming a Diversified Open-end Investment Company that might be to our advantage. It is realized at this time that we cannot make final plans until further information and rulings are obtained from the Internal Revenue Service and the Federal Securities Administration.

Insurance Coverage for Mental Illness

As directed by the House of Delegates through Council, this Board has investigated the availability of hospital coverage for mental illness and it was found that the Columbus Blue Cross has an extended hospital service plan to include all mental illness up to 30 days and many insurance companies provide hospital coverage for mental illness and have done so for many years.

It is recommended that the members of the Medical Association of Georgia inform themselves as to available insurance coverage for their patients, as well as themselves, and that they advise careful study of insurance as offered, being certain to take into consideration the details of the type of insurance protection desired and follow the general guide as to exclusions, age limit and incidental expenses. Particular attention should be given to the availability of continuing the insurance program after retirement, if it happens to be a group policy. It is felt that understanding and cooperation between the Medical Profession and the insurance industry is desirable and that at the present time very good liaison exists between the Medical Profession and the insurance industry and this should be fostered and encouraged on an individual, local, state and national level.

Relative Value Study Sub-Committee

HARRY D. PINSON, M.D., *Chairman*

As Chairman of the Sub-Committee on Relative Value Study of the Medical Association of Georgia, I wish to submit the following report.

The Committee is in the process of conducting a survey for revision of the Relative Value Study. This study cannot be completed until later in the year and a more detailed report will be submitted for the year of 1964 after the study is completed.

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves and commends the report of the Insurance and Economics Board and of the Relative Value Study Sub-Committee.

The Committee approves the continuation of the Georgia Plan and recommends that thanks be given to Mr. H. B. Coolidge for his valued services.

The Committee approves the recommendation that every effort be made to encourage employees to continue coverage for hospitalization, health and accident, and other medical benefits after retirement, and that employers be encouraged, where possible, to provide post-retirement coverage for their employees.

The Committee approves the recommendation that the members of the Medical Association of Georgia inform themselves as to available insurance coverage for their patients, as well as themselves, and that they advise careful study of insurance as offered, being certain to take into consideration the details of the type of insurance protection desired and follow the general guide as to exclusions, age limit and incidental expenses.

HOUSE OF DELEGATES ACTION—Adopted the report of the Insurance and Economics Board and of the Relative Value Study Committee as recommended by the Reference Committee and seconded.

Legislation

SAMUEL U. BRALY, M.D., *Chairman*

J. FRANK WALKER, M.D., *Chairman*
National Legislation

JOHN A. BELL, M.D., *Chairman*
State Legislation

The legislative affairs of MAG continue to be, perhaps, the single most important project area undertaken by the Association during the past twelve months. Without question, legislation, both proposed and enacted, affects more members of the profession than any other area of activity to which MAG and its members are exposed.

Last July the United States Senate voted 52 to 48 to defeat a substitute version of the King-Anderson bill. Since that time the national legislative program of MAG can best be described as one of regrouping, planning and strategizing in general for our 1963 defense against this same legislation.

Your Legislative Board and its duly constituted Sub-Committees on National and State Legislation have devoted considerable time and effort to the development of a Speakers Bureau at the state and local level. We have encouraged a program at both levels designed to draw more physicians into the campaign. We have sought and obtained speaking engagements and debates in every corner of the state in an effort to better inform the lay public and enhance the position of the profession on the Social Security medicine issue.

A visitation program is underway and is expected to be completed prior to the dates of the Annual Session. This visitation program is designed to shore up MAG defenses at the local County Medical Society

level and well arm MAG members with weapons to take the offensive in what is becoming the annual King-Anderson battle.

Immediately prior to last year's historic Senate King-Anderson vote (first time 100 votes had ever been cast on a single bill in Senate) your Legislative Board sponsored its Fourth Annual Congressional Luncheon for members of the Georgia Delegation in the Congress. The usual format: luncheon in the Speakers Dining Room at the U. S. Capitol, following a morning of visiting with our Congressmen, was again observed. One member of MAG from each Congressional District acted as personal host for his Member of Congress. All but two members of Georgia's 12-man delegation attended and it was generally agreed that these luncheons do much to improve the relationship between Georgia physicians and their official representatives in Washington.

State Legislative Activity

Legislative Activity on the State level was a matter to which particular attention was given during the past year. Amid the political climate inspired by the election of a new Governor and the court-ordered reapportionment of the State Senate, your Board and its State Legislation Sub-Committee considered many bills which were presented to the General Assembly for action.

Two bills which MAG had planned to sponsor, pursuant to an action taken by the 1962 MAG House of Delegates, require special mention.

The first of these two bills was one designed to strengthen the Georgia Medical Practice Act by requiring a year's internship as a condition for licensure. This bill was drafted four separate times in an effort to perfect its language. The author of the bill, Dr. John Acree, a member of the House of Representatives from Towns County, was suddenly taken ill and did not return to the Capitol until approximately one week before adjournment. Feeling that there was insufficient time in which to introduce this bill and have it work its way through the legislative machinery to ultimate enactment, Dr. Acree concluded that rather than stigmatize this bill by having it lay over a year, that it would be wise to hold the bill and introduce it early in the 1964 session of the Legislature. Your Board concurs in the wisdom of this decision.

The other bill which the House of Delegates mandated MAG to sponsor was a bill to provide for the confidential character of medical studies conducted by the Department of Public Health, MAG and others. Again this bill was late in being perfected and it was concluded that it also should be held over until 1964 rather than have it lay as pending legislation for the balance of this year.

Legislation sponsored by the Georgia Podiatry Association to force Blue Shield Insurance plans to extend their policy contract to include coverage of podiatric services was again introduced in the General Assembly. Their first attempt to secure passage of this legislation during the 1963 session was defeated in the Senate Health and Welfare Committee. The bill was originally given a "do pass" label by the Committee, but was then recommitted to the Committee for further consideration. A second vote reversed this position and the bill died in Committee. After having failed in the Senate, the Podiatry Association then sponsored a

modified version of this bill in the House. MAG opposed this bill at every step: in the Insurance Committee, the Rules Committee and on the floor of the House where the bill was ultimately "put aside" on a motion to table.

Another bill of major concern to the medical profession was that of recodification of all public health laws in Georgia. After two years of close liaison with the Department of Public Health and members of the Joint Interim Study Committee of the General Assembly, MAG placed its endorsement on this legislation. However, the House Hygiene and Sanitation Committee amended this bill in several particulars with the result that MAG felt compelled to withdraw its endorsement and actively oppose the bill as amended. The bill was eventually recommitted to the Hygiene and Sanitation Committee for another year's study. It will be offered to the full House again next year.

This bill as amended by the House Committee sought to reorganize the State Board of Health in such a manner as to reduce the number of physicians on the Board from 11 to three and to cut in half the number of dentists and pharmacists on the Board. The ultimate composition of the Board under the Committee version would be three physicians, one dentist, one pharmacist and ten persons of undisclosed qualifications appointed by the Governor.

Your Board feels constrained to recommend that MAG adopt a strong position opposing this move should it be presented in the same form at the 1964 session of the General Assembly. The House of Delegates may wish to consider some alternate reorganization plan, but your Board would recommend against any change which results in the balance of control shifting away from medically oriented personnel on the Board of Health. Currently, and for the past 30 years, the Board of Health has been composed of 11 physicians, two dentists and two pharmacists.

Among other items of legislation in which your Board and its Sub-Committees represented MAG included: Seat belt legislation, Workmen's Compensation bills, dental scholarships, a bill to reorganize the Board of Medical Examiners so as to have one representative from each Congressional District and many others.

Recommendations

Two years ago MAG established a County level Keyman system wherein approximately 130 of Georgia's 159 counties had a given physician designated as Legislative Keyman. His purpose was to act as liaison between MAG and his State Representatives and Senators from his County. This system has proved workable but has not been as diligently pursued as the best interest of the profession requires that it be. Accordingly, your Legislative Board recommends that County Society Presidents and Secretaries make a special point of establishing closer working agreements with the Legislative Keyman for their County in order that the entire County Medical Society may be called upon when request for assistance is made by MAG. The only way your legislative program can be successful is for many people on the local level to be ready and willing to do the personal contact work. One Legislative Keyman cannot do this on all issues of importance to the profession.

Commendations

Your Board would like to pay special tribute to three physicians who not only recognize the importance of political and legislative affairs but who have given of their time and talents in this regard. Doctors John Acree, Hiawassee; Grady Coker, Canton; and Sidney Johnson, Sr., Elberton, were all successful candidates for the House of Representatives in the State elections last fall. Their efforts in behalf of good medical legislation deserve the commendations of the House of Delegates and your Board wishes to extend its personal thanks to these physicians for a job well done.

In addition, the Legislative Board wishes to thank Mr. Francis Shackelford and Mr. John Moore for the assistance rendered during the past year in the field of legislation. The fine work accomplished by Mr. James Moffett is well known by one and all and needs no elaboration here.

Conclusion

In closing, your Board cannot overstress the urgent need for a new political awareness on the part of physicians, their wives, their office help and others with whom physicians daily come in contact.

At no time in the long history of the medical profession has there been a greater need for dedicated men in the profession. Not only does the profession stand to lose much from inactivity and apathy on the part of its practitioners, but the country itself is desperately in need of leadership from one of its most knowing and talented professions. State and national legislation viewed in its totality presents a monumental challenge and a monumental opportunity. Your Board urges a reappraisal by every County Medical Society of the part it can play in this overall picture.

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves and commends the report of the Legislative Board.

The Committee strongly endorses the recommendation of the Legislative Board opposing the proposed reorganization of the State Board of Health.

The Committee feels that it is in the best interest of the general public as well as the medical profession that such a change in the orientation of the membership of the State Board of Health does not take place.

The Committee approves the recommendation that County Society Presidents and Secretaries make a special point of establishing closer working agreements with the Legislative Keyman for their Society in order that the entire County Medical Society may be called upon when request for assistance is made by MAG. The only way your legislative program can be successful is for many people on the local level to be ready and willing to do the personal contact work. One Legislative Keyman cannot do this on all issues of importance to the profession.

HOUSE OF DELEGATES ACTION—Adopted the report of the Legislative Board as recommended by the Reference Committee and motion duly made and seconded.

Report of the Journal

EDGAR WOODY, JR., M.D., *Editor*

The 1962-63 report of the Journal of the Medical Association of Georgia is submitted herewith:

Personnel

Since the last annual report Miss Virginia Gaines submitted her resignation as Managing Editor. It was with much regret that her resignation was accepted. She was replaced by Miss Merrillie Davis, a graduate of the

Women's College of the University of North Carolina. Prior to her employment with the *Journal*, Miss Davis was a teacher of English in the Atlanta public school system.

During the past year, there have been no changes in our staff of contributing editors. Our editorial staff has continued to be very helpful with their editorial contributions and with their solicitation of desirable scientific material for publication.

Conferences

November of 1962, the Editor and Managing Editor attended a conference of Medical Editors in Denver. This program was especially helpful for Miss Davis since she had so recently assumed her new duties. Representatives from approximately 20 state medical journals were in attendance at this meeting.

Advertising

Advertising revenue from national sources continued to drop slightly during the year just past, but due to increased efforts on the part of the Headquarters Office personnel, local advertising has been increased considerably so that our deficits from national advertising have been partially replaced. Our national advertising agency, the State Medical Journal Advertising Bureau, Chicago, continues to perform its functions efficiently in our behalf.

Content

During the past year the *Journal* has begun a new feature entitled, "How Well Are We Telling Our Story?" This feature is built around a map of the State of Georgia on which are shown localities where physicians have spoken before lay audiences on any subject. This feature was intended to mirror for our doctors the extent of our efforts in communicating with the lay public. While most of our maps have shown marked deficiencies in our efforts at communication, we feel that this can serve as a stimulus for doctors to get out and reveal our viewpoints to the lay public. So far, many favorable comments have been received about this feature.

Other features which remain active in the *Journal* are: The President's Letter, the Mental Health Page, the Heart Page, the Cancer Page, the Legal Page, Current Clinical Concepts, Physicians' Bookshelf and Abstracts of Georgia Authors.

Our yellow insert page, The Top of the News, continues to perform a real service for us in getting out late news to our physician readers in concise telegraphic style.

During 1962, the *Journal* mailed approximately five supplements calling attention to important activities currently being sponsored or recognized by the MAG. The supplements are mailed under the same cover with the *Journal*.

Format and Typography

During the past year increasing use has been made of glossy photographs for use on our *Journal* covers. These photographs have been obtained from diverse sources and most have been without cost to the *Journal*. They have been used to highlight scientific editorials

or scientific papers in the *Journal*. Small changes and improvements have continually been made in the typography of the *Journal* though no radical changes have been effected.

Thanks are due to Mr. Milton Krueger, Mr. Jim Moffett and the other members of the Headquarters Office staff who have been of great assistance during the past year in supplying news of the activities of the Association for the columns of the *Journal*.

A continuing effort has been made to produce a *Journal* of superior quality and one which consistently reflects the policies and programs of the Association. Any constructive suggestions for improvement of your publication will always be welcomed by the Editor.

REFERENCE COMMITTEE RECOMMENDATION—The Committee accepts and commends the report of the Editor of the *Journal*, and in line with his request for suggestions for improvement, recommends that the Editor of the *Journal* be empowered to accept or reject any scientific paper submitted for publication.

HOUSE OF DELEGATES ACTION—Adopted the report of the *Journal* of the Medical Association of Georgia as recommended by the Reference Committee and the additional recommendation of the Reference Committee on motion duly made and seconded.

Resolution No. 2

INTRODUCTION OF A BILL PROPERLY DEFINING THE PRACTICE OF PODIATRY

ROBERT E. WELLS FOR FULTON COUNTY
MEDICAL SOCIETY

Whereas, for the last several years bills have been introduced into the Georgia Legislature in an effort to extend the realm of practice of podiatrists by including coverage for their procedure under Blue Shield Insurance Plans, and

Whereas, considerable expenditure of effort and time by the Medical Association of Georgia has been required in opposition to these bills each year, and

Whereas, the present legal definition in the Code of Georgia defining the practice of podiatry is vague and ill defined,

Now, therefore, be it resolved that the Medical Association of Georgia shall investigate a modification of Section 84-601 of the Code of Georgia and, if indicated, seek the introduction of a bill in the Legislature of the State of Georgia to modify said Section.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee recommends the adoption of Resolution No. 2 with this addition:

The Committee, after much discussion and comment from several interested physicians accepts this Resolution and makes the following suggestion: That the matter be referred to Council for (1) further study of educational requirements of podiatrists; (2) preparation of legislation for consideration; (3) prompt transfer of Council's recommendation to the Legislative Board.

HOUSE OF DELEGATES ACTION—At this point, President Thomas Goodwin, Augusta, rose to a point of order to inquire that if this Reference Committee recommendation on Resolution No. 2 is adopted, would the Council have the power to act on the matter. After discussion, on motion (Wells-Dowda) it was moved and duly seconded that Council would be instructed to act on this matter if Resolution No. 2 is adopted. After further discussion, the question was called and the motion to instruct Council to act on this matter, if Resolution No. 2 is adopted, was approved.

The House then adopted the Resolution No. 2 including the suggestions of the Reference Committee on the implementation of Resolution No. 2.

Resolution No. 5

HEALTH CARE OF THE AGED

WILLIAM W. MOORE, JR. FOR FULTON COUNTY
MEDICAL SOCIETY

Whereas, there is now pending in the Congress of the United States legislation entitled the "Hospital Act of 1963," more commonly known as H.R. 3920 or the King-Anderson Bill, and

Whereas, this is another in a long series of attempts to place extraordinary controls on the practice of medicine, and

Whereas, this legislation, ostensibly conceived for the purpose of helping those of a certain age group whose financial position has been arbitrarily determined to be inadequate, would in fact grant financial assistance to virtually everyone, regardless of need, and would inevitably result in an expanded program to cover all persons of all ages, regardless of circumstances, and

Whereas, enactment of H.R. 3920 or similar legislation utilizing the Social Security mechanism as a financing vehicle, would increase Social Security taxes, thus placing a disproportionate share of the burden of financing this program on the low wage earners, and

Whereas, this Act would result in the overcrowding and overutilization of hospitals by those, many of whom could be better cared for at home, and

Whereas, H.R. 3920 would seriously lower the quality of medical care in the United States, and would limit the patient's free choice of hospitals to only those hospitals who sign agreements with the Federal Government and to those physicians who practice in these hospitals, and

Whereas, the need for such a program has been grossly overstated, failing to take into account the great strides made in voluntary health insurance, and

Whereas, the progress made under State implementation of the Federal Kerr-Mills Law has been shamelessly ignored by the proponents of this legislation, and

Whereas, the Kerr-Mills Law is totally adequate to render the finest care possible to those who actually need help, and

Whereas, the cost of such a program would be astronomical from the beginning and would grow bigger each year with the result that additional increases in Social Security or other taxes would be inevitable,

Now, therefore be it resolved, that the Medical Association of Georgia does hereby go on record as being unalterably opposed to the passage of H.R. 3920 or any similar legislation which ignores need as a condition of eligibility or which utilizes the Social Security System as a financing device and thereby implying that mere coverage under Social Security is tantamount to an individual's inability to care for himself, and

Be it further resolved, that the Medical Association of Georgia does hereby solicit the support of the Georgia Delegation in the Congress to oppose H.R. 3920 or similar legislation in a vigorous and determined manner, and

Be it further resolved, that the Speaker of the House of Delegates of the Medical Association of Georgia be instructed to dispatch a copy of this Resolution to each member of the Georgia Delegation in the Congress and that such Resolution appear over the official signatures

of each member of the Executive Committee of Council of the Medical Association of Georgia.

REFERENCE COMMITTEE RECOMMENDATION—The Committee recommends the adoption of Resolution No. 5: Health Care of the Aged.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 5: Health Care of the Aged as recommended by the Reference Committee on motion duly made and seconded.

Resolution No. 7

EXPANSION OF GEORGIA'S KERR-MILLS PROGRAM

LINTON H. BISHOP, JR. FOR FULTON COUNTY
MEDICAL SOCIETY

Whereas, legislation enabling the State of Georgia to establish a program of medical, hospital and nursing home care, pursuant to the federally enacted Kerr-Mills Law, was adopted by the General Assembly of Georgia in 1961, and

Whereas, this enabling Act was passed and signed into law for the purpose of giving financial assistance to two separate and distinct segments of Georgia's aged population, and

Whereas, these segments of Georgia's aged population are by definition of said Act recipients of:

- (1) Old Aged Assistance (OAA) health care benefits for the "needy" who are over age 65 and who are being carried on the Welfare Department relief rolls; and
- (2) Medical Assistance to the Aged (MAA) health care benefits for the "near-needy" who are over age 65 and who would be determined to be medically indigent such as those persons who could sustain themselves for ordinary living expenses (food, clothing, shelter) yet could not afford an unusual hospital expense, and

Whereas, such Act is sufficiently inclusive as to permit the best and most extensive care possible for those in need and thus obviates the necessity for additional implementation legislation, and

Whereas, there is widespread interest among the peoples of Georgia for the expansion of this program, and

Whereas, the actual need for expansion into the the Medical Assistance to the Aged (MAA) portion of the enabling Act is both great and immediate, and,

Whereas, state monies have been allocated for the implementation of only that portion of the law relating to benefits paid under the Old Age Assistance (OAA) section of said Act, and

Whereas, Georgia enjoys a favorable ratio of Federal to State matching funds with which such expansion would be financed, and

Whereas, the experience gained through the implementation of the OAA portion of the Act gives evidence, clear and positive, of the feasibility and sound management techniques which would be brought to additional expansions of the Act.

Now, therefore be it resolved, that the Medical Association of Georgia go on public record giving its strongest possible endorsement to the expansion of this program at the earliest possible date and that such expansion be sufficiently financed, consistent with all other state obligations, as to insure a workable, ade-

quate and thoroughly effective program of health care of the aged, and

Be it further resolved, that the Medical Association of Georgia actively encourage, through appropriate channels, expansion of Georgia's Kerr-Mills program into the MAA classification.

REFERENCE COMMITTEE RECOMMENDATION — The Committee recommends the adoption of Resolution No. 7: Expansion of Georgia's Kerr-Mills Program.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 7: Expansion of Georgia's Kerr-Mills Program as recommended by the Reference Committee on motion duly made and seconded.

It was moved by Reference Committee No. 4, Chairman William Moore, Atlanta, and duly seconded that the report of the Reference Committee be approved as a whole and it was so ordered.

Report of Reference Committee No. 5

Jule C. Neal, Macon, Chairman

(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendation for the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 5 met in the Rotunda of the Aquarama, Jekyll Island, Georgia, at 2:30 p.m., May 6, 1963. Members present were: Jule C. Neal, Macon, Chairman; C. M. Johnson, Eastman, Vice Chairman; F. M. McElhannon, Athens, Secretary; Robert Wells, Atlanta; J. P. Hoover, Rossville; W. H. Fulmer, Savannah; Virginia Tuggle, Decatur, and E. L. Harrell, Jesup.

Interprofessional Relations

J. G. McDANIEL, M.D., Chairman

The Interprofessional Council meets four times yearly. It is composed of representatives from the physicians, dentists, veterinarians, and pharmacists.

These meetings have been most helpful to all the professions.

The three representatives from the Medical Association of Georgia have attended all the meetings and effective liaison is derived from these discussions.

Dr. William A. Wood of Atlanta is currently serving as President of this Council.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee recommends approval of this report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the Interprofessional Relations Board as recommended by the Reference Committee on motion duly made and seconded.

Medical Education

T. A. SAPPINGTON, M.D., Chairman

The report of the Board of Medical Education is in the minutes of its one meeting and reports from each of the four Sub-Committees.

The minutes and the report of each Sub-Committee follows:

The meeting of the Medical Association of Georgia Medical Education Board was called to order by Chairman T. A. Sappington at 2:15 p.m. on February 24, 1963, at the MAG Headquarters Office Building, Atlanta, Georgia.

Members of the Board present included: T. A. Sappington, Thomaston, Chairman; Walter Bloom, Marietta; Braswell Collins, Macon; and W. H. M. Weaver, Macon. Also present was Mr. Milton Krueger of the Headquarters Office Staff.

Dr. Sappington reported on the Medical School Sub-Committee activity, and he stated that because of other matters and for a re-evaluation, the annual course "Art of the Practice of Medicine" had not been scheduled for January through March of 1963. He discussed the fine reception for this course in the past five years at the Medical College of Georgia and the difficulty in scheduling such a course at Emory University School of Medicine. He assured the Board that the course would be scheduled for 1964.

Dr. Walter Bloom reported on the activity of the Medical Education Sub-Committee, and reported on attending the AMA Congress on Medical Education and Licensure held in Chicago in February.

Dr. Bloom outlined a program of medical recruitment, describing the Oklahoma brochure, the AMA Medical Career Kit, the AMA movie, "I Am A Doctor," and the AAGP Project "More." Dr. Bloom cited these tools for use in a medical recruitment project, and it was recommended that Dr. Bloom rough draft a plan and a brochure for M.D. recruitment in Georgia and include this plan in his report to the MAG House of Delegates which will also be incorporated in Medical Education Board Chairman T. A. Sappington's report.

Dr. Bloom then also outlined a proposed Georgia Conference on Medical education to be held in the State of Georgia on a statewide basis. The Board recommended that Dr. Bloom propose a plan, program and other details of such a meeting and work with Board Chairman Sappington in this connection so that the meeting may be convened late in 1963.

Dr. Bloom also discussed for some future date the Association co-sponsorship with community hospitals or medical societies of scientific programs. It was the recommendation of the Board that this project be held in abeyance at this time but be given full consideration in the near future.

Dr. Braswell Collins reported on activity of the AMA-ERF Sub-Committee which replaces the AMEF Committee.

After due discussion of medical education matters in general, the meeting was adjourned at 3:45 p.m.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee recommends approval of this report and acceptance with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the Medical Education Board as recommended by the Reference Committee on motion duly made and seconded.

AMA-ERF Sub-Committee

BRASWELL E. COLLINS, M.D., Chairman

The purpose of the American Medical Association Education and Research Foundation is to help Medical Schools arrange scholarship loans to medical students

and to further medical teaching. There is a great need for finances beyond the annual budget of a school.

The program was started in March 1962, to help qualified, needy medical students, interns, and residents during their years of training. The loan program is now nearing \$10,000,000 with nearly one out of every ten medical students receiving needed aid. Commercial banks make the loans up to \$12.50 for each dollar in the fund as security. This has been one of the most successful programs of the AMA.

Funds may be contributed directly to a school, through alumni associations or through AMA-ERF earmarked for any specific school. One advantage in contributing through the AMA-ERF is to have a record of what doctors are doing on a national scale for the medical profession instead of relying on the government. These contributions are income tax deductible.

It is recognized that ladies are better fund raisers than men. Doctors are reluctant to solicit other doctors for funds although they are quite active in heart, cancer, polio, etc. drives. Raising funds is difficult for any group but a few suggestions may help.

"With Sympathy" cards are obtainable for the Auxiliary to distribute. Instead of sending flowers to a bereaved family, a contribution could be made to AMA-ERF. A note of receipt and appreciation would be sent to the donor and bereaved family from the medical school.

"In Appreciation" cards can be used in the same manner. This appreciation is for a service or favor rendered such as gratis surgery or medical care to a doctor's family.

"Doctors' Day" parties are good affairs for fund raising. The doctor is honored and also rather elated and generous for the occasion. A "Supper Party" at extra cost could be arranged. One society auxiliary weighed each doctor present who then contributed a penny per pound of weight. This promoted dieting before the next annual affair.

At another Doctors' Day Party a "Wishing Well" was provided for coins and also personal checks. The committee had blank checks available on all local banks. A Bingo party can provide fun and funds.

A "Pink Elephant" sale has been successful. Something old to you may be new to someone else.

A final suggestion for fund raising is for two or three sweet auxiliary members to visit the doctor's reception room and ask for a financial treat instead of a treatment. This would be all profit for AMA-ERF.

The above report is submitted by your committee in a spirit of helpfulness to further this most worthwhile project.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee recommends approval of this report and acceptance with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the AMA-ERF Sub-Committee as recommended by the Reference Committee on motion duly made and seconded.

Medical Education Sub-Committee

WALTER LYON BLOOM, M.D., *Chairman*

The Sub-Committee on Medical Education has been active this year in attending the Conference on Medical Education of the American Medical Association. This

Conference represented the usual conference of the AMA, and in addition a workshop put on by the Directors of Medical Education in the independent non-profit hospitals. This workshop was most productive in discussing aspects such as a medical audit, techniques of conducting teaching rounds, audiovisual aids, the value of the lecture and in general a review of methodology of postgraduate and continuing education in the community hospital. The Conference on Medical Education followed its usual pattern and it appears to the reviewer that the same people managed to continue saying the same things at this conference and that it is high time that some initiative and originality be introduced into the programming. Actually the problems discussed, usually, are not related to the major patient care needs in this country and the congress could well stand some degree of rejuvenation.

There was a general meeting of the Education Committee and two specific projects have been undertaken. The first recommendation was to prepare a pamphlet to be distributed to high school students who might be interested in medical or associated scientific careers. It was also felt that it would be advisable to set up counseling by physicians for young people interested in medicine, rather than have this counseling done by people who have neither knowledge, nor skill, nor experience in the field about which they are discussing. In this way it might be possible to renew the interest of young people in anticipating their life's work in a medical career. The second project under discussion which was recommended was that a statewide conference on postgraduate and continuing education be held in the fall and that this conference be oriented towards intern and residency training as well as continuing education in the independent non-profit hospital.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee recommends that MAG approve with commendation the report and the idea set forth in the report with implementation.

HOUSE OF DELEGATES ACTION—Adopted the report of the Medical Education Sub-Committee as recommended by the Reference Committee on motion duly made and seconded.

Medical School Course Sub-Committee

T. A. SAPPINGTON, M.D., *Chairman*

The Sub-Committee on Medical School Courses did not meet to arrange courses this year. This was partly due to the inefficiency of its Chairman but also to give the speakers a year's rest and to see if the courses are really missed and really wanted at the Medical College of Georgia. It is felt that the lectures were missed and are a valuable part of the curriculum. It is anticipated that these courses will be given at the Medical College of Georgia next year and it is hoped that they can also be given at Emory Medical School.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee recommends approval of this report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the Medical School Course Sub-Committee as recommended by the Reference Committee on motion duly made and seconded.

Public Service

LINTON BISHOP, M.D., *Chairman*

The Public Service Board has been active during the

Association year of 1962-1963. We have initiated several new projects to be based at the Association Headquarters. The first of these is an MAG Public Service Information Clearing House. The purpose of this Clearing House is to accumulate information on projects carried out by doctors throughout the state so that this information will be available to future societies which are interested in initiating like projects.

Dr. Dick Stribling of Gainesville was appointed Chairman of the Sub-Committee to implement this Information Clearing House.

County Medical Society Speakers Bureau

We are attempting to set up a Speakers Bureau with participations from the local medical societies and request that each component society of MAG appoint a physician willing to talk in the area of his county medical society on scientific and un-scientific subjects.

Traffic Safety

Efforts were made to make this a Speakers Bureau topic and are cooperating with the Highway Patrol to further plan ways in which MAG can promote greater traffic safety.

Weekly Health Column

The Weekly Health Column has been active under the leadership of Dr. Rhodes Haverty. A report of this Sub-Committee follows. I wish to thank Dr. Haverty and the doctors who have spent so much time making the Weekly Health Column an outstanding success.

Annual County Medical Society Officers Conference

This was an area of major endeavor for the Public Service Board. The Conference was held in Atlanta, March 2-3, 1963, on the theme of "The Public Be Served." Special emphasis was placed on a youth fitness program and the Public Service Board hopes that the physicians of Georgia will initiate one in their various communities. Politics and medicine was discussed in detail and we had outstanding presentations from some authorities on this matter.

The Public Service Board recommends a continuation of this Conference and the active participation in these meetings by the leadership and these component medical societies.

This Board also implemented the Medicine and Religion program of AMA and held conferences in Americus with the active participation of the Sumter County Medical Society and the Sumter County Ministerial Association. This meeting was a success and has urged a few future meetings of this type between medicine and religion to be held throughout the state.

It is still a major function of the Public Service Board to help physicians initiate programs of vital concern to their communities and to tell the story of medicine to the public through actions as well as words. Our general plans for the next year are to continue the projects mentioned and to look for new ways in which the best interest of the public can be served by medicine.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee recommends approval of this report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the Public Service Board as recommended by the Reference Committee on motion duly made and seconded.

Weekly Health Column Sub-Committee

J. RHODES HAVERTY, M.D., *Chairman*

In 1958 the Weekly Health Column Sub-Committee was organized and since that time has been a very active committee. The committee meets on an average of every three months and in 1962 prepared 55 articles for publication. These articles have been on subjects of popular interest related to medical and health care.

The Weekly Health Column is mailed to 232 weekly and daily newspapers in Georgia. About 200 weekly newspapers publish the articles and about ten daily papers. The committee is still assisted by the professional science writer who helps in editing the columns for lay readership.

The Chairman of the committee recommends continuance of this project in the interest of serving the citizens of Georgia. The editors of the newspapers have been encouraged to take advantage of this MAG service, and the readers have been encouraged to write the committee regarding subjects of interest for future publication. Many inquiries have been received, which indicate reader interest in this column.

The Chairman wishes to thank the members of the MAG Council and the MAG Finance Committee for their interest in the continuance of this project. The Chairman also wishes to commend all of the members of the committee who have worked so diligently during the year, and to thank Miss Edwina Davis, science writer, and Mrs. Catherine Wooten, MAG staff assistant, for their contributions to the successful functioning of this committee.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee recommends approval of this report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the Weekly Health Column Sub-Committee as recommended by the Reference Committee on motion duly made and seconded.

Public Service Sub-Committee

FLOYD R. SANDERS, JR., M.D., *Chairman*

The Sub-Committee on Public Service has not been presented with business requiring a meeting of the Committee as a whole. However, the chairman was requested at a recent meeting of the Board of Public Service to visit Colonel Connors of the Georgia Highway Patrol to discuss the matter of traffic safety and express the desire of the Medical Association of Georgia to be of service on any project in this area. To date this has not been completed, but plans are under consideration to conclude this in the very near future.

The only other activity of the Committee involved the Chairman's participation in the recent County Society Officers Conference on March 2-3, 1963, which featured as its theme "The Public Be Served."

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee recommends approval of this report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the Public Service Sub-Committee when the Reference Committee report as a whole was adopted.

Mental Health Sub-Committee

JAMES N. BRAWNER, JR., M.D., *Chairman*

With the recent appointment of an enlarged Mental Health Sub-Committee, our retiring and in-coming

presidents have expressed their awareness of the fact that we are at the beginning of a new mental health era in the state of Georgia. They have also indicated the need for the Medical Association of Georgia to assume its proper position of leadership in meeting the current major health problem of the nation and our state. This effort is in support of the national program which has been initiated by the American Medical Association with full cooperation of the American Psychiatric Association and the National Association for Mental Health.

The foundation and impetus of the AMA plan is the published report of the Joint Commission on Mental Illness and Health entitled "Action for Mental Health." This is the most thorough study of its kind, "—to analyze and evaluate the needs and resources of the mentally ill people of America and make recommendations for the national mental health program." This report was presented to Congress, the Governors and the Legislatures of our states.

Little action was evident toward an authoritative ongoing program until the Council on Mental Health of the AMA, with approval of the AMA Board of Trustees and House of Delegates, sponsored and convened the first National Congress on Mental Illness and Health in Chicago, October 4-6, 1962. This meeting was comprised of representatives of all state medical, psychiatric and mental health associations, as well as nurses, social workers, health department officials, hospital administrators, ministers, laymen and many others interested in some aspect of mental health. The attendance exceeded expectations, and enthusiasm was high. At least 25 registrants were from Georgia.

The Medical Association of Georgia was ably represented by Dr. August Yochem, Jr., who also served as chairman of the Georgia Steering Committee. Dr. Yochem's report to MAG Council on December 5, 1962, a copy of which is on file, was prefaced by the recommendation that greater emphasis be placed on "—participation of more non-psychiatric physicians for the purpose of implementing the broad, new Mental Health program of the AMA;" and, for the purpose of transforming the general concepts of this program from "a national level to positive recommendations—needed in this state, the Medical Association of Georgia must be the important instrument for action and leadership." Your committee recommends that Dr. Yochem's report be approved and supported as our first step toward positive action for improved mental health in Georgia—for patient care, public education, training of personnel and research.

In Dr. Yochem's report, Item 3 referred to the need for "a highly skilled psychiatrist as full-time Director of Mental Health within the Department of Public Health." On March 1, 1963, Dr. Addison Duval assumed the position, and we welcome him heartily. Dr. Duval is a highly skilled and qualified psychiatrist and is also experienced in this area of mental health. Your Sub-Committee on Mental Health will benefit by having Dr. Duval as an ex-officio member. To him we shall look for counsel, advice and assistance; and with him we shall be most willing to cooperate for better mental health for our state.

The American Medical Association has published a comprehensive report of the Proceedings of the National Congress on Mental Illness and Health. This in-

cludes excellent summaries of intensive group discussions of many important aspects of mental health, as well as the results of regional meetings of smaller geographical areas. In the latter, representatives from Georgia participated with those from South Carolina and Florida. For the benefit of all physicians and members of the Woman's Auxiliaries, your Sub-Committee would like to publish a summary of these reports.

In early March 1963, Dr. Shannon Mays represented this committee and the Medical Association of Georgia at a follow-up meeting to the National Congress. Here the Council on Mental Health of the AMA, with representatives from all state medical associations and departments of health, discussed further means by which the national mental program can be made effective on state and community levels. Another topic of discussion was President Kennedy's recent message to Congress on "Mental Illness and Mental Retardation," in which he, on the date February 5, 1963, calls for a National Mental Health program! Immediate reference to "Action for Mental Health" is made by the President in the official Congressional Document No. 58, but any reference by him to the long planned and previously activated program of the American Medical Association was conspicuous by its omission! However, Dr. Mays reports that a fellow Georgian formerly of Emory University, Mr. Boisfeuillet Jones, now of the Health, Education and Welfare Department, was a participant and presented a paper on the Federal Government's Mental Health program. It appeared that representatives of the AMA, APA, State and Federal Mental Health Agencies were in close agreement with President Kennedy's program.

Another recurrent theme of the meeting was that "Psychiatrists must get back into the mainstream of organized medicine." It was felt that they have over the years, progressively isolated themselves from organized medicine, especially so in general hospitals, in our County Medical Societies, and even in the peculiar and esoteric terminology of our specialty. It is hoped and believed that all psychiatrists in Georgia will fall into line so as to remedy this problem.

Dr. Mays also reported that this meeting afforded him the opportunity to get to know Dr. John Venable, Director of our State Public Health Department, and Dr. Addison Duval, recently appointed Director of the Mental Health Division. They spent some time discussing our immediate and long term mental health plans and some of the misunderstandings which have arisen mainly through a breakdown in communication between our Mental Health Committee, the Georgia Psychiatric Association, and the state mental health agencies. This time spent together established the beginning of a healthy, two-way communication system.

In order to launch a continuously positive state-level program for improved mental health, your Sub-Committee asks for your support in the primary areas of Organization and Communication by:

1. Appointment of Rotating Mental Health Committees of the State and County Societies and their Auxiliaries, comprised of members who are really interested in promoting mental health work in our state;

2. Effective means of communication to be established and maintained between these committees on state and local levels, with public health officials, mental health associations, other professional groups, ministers, lay and civic organizations;

3. An active State Mental Health Steering Committee to function as a central coordinating group in which all state organizations and agencies active in the mental health field shall have one representative; and,

4. The use of the Medical Health page of the *Journal of MAG* for regular publication of Mental Health News, with special emphasis on implementing the AMA program in our state, counties and communities.

Finally, your Mental Health Sub-Committee shall strive for organization and communication to enhance education and progress. We welcome suggestions, advice and criticism from physicians, medical societies, their auxiliaries, related professions, public officials and civic groups; and, in turn, wish to assure each that members of this committee shall stand ready to assist. Above all, we ask for help from all on this important venture, especially from the officers, members of Council and the House of Delegates of the Medical Association of Georgia.

REFERENCE COMMITTEE RECOMMENDATION—The report of the Mental Health Sub-Committee was received for information and it was recommended that it be referred to Council.

HOUSE OF DELEGATES ACTION—At this point, Dr. Thomas Goodwin requested clarification on the Reference Committee recommendation as to whether or not Council is empowered to act on the matter. After some discussion, on motion (Charles Smith-A. G. Funderburk) it was moved that Council be instructed to act on the Reference Committee recommendation. In discussing this motion, Dr. J. P. Hoover stated his reason for opposition to the motion and moved in a substitute motion (Hoover-Neal) to refer the report to Council for whatever action they see fit. The substitute motion was then approved and the House adopted the Reference Committee recommendation on the Mental Health Sub-Committee report as clarified.

Special Activities

JOHN S. ATWATER, M.D., *Chairman*

The Board of Special Activities has continued to work in its two main assigned functions, namely, the continued conduct of the MAG Physician's Placement Bureau, and the Health Care of the Aging Sub-Committee.

As in the past the Board has worked in liaison with the State Board of Medical Education. The listings of both physicians and localities seeking placements are kept current and revised on a three months basis. It is hoped that this continued activity will further aid the citizens of Georgia as well as the physicians in the placement of physicians in key locations.

The Health Care of the Aging Sub-Committee has continued its activities much as has been reported in the last several years with continued efforts to support the Kerr-Mills program and to educate the public as well as physicians to the current social legislation. This is accomplished through liaison with other Committees of the Medical Association of Georgia and by personal appearances of various Committee members and Association members before appropriate civic, social and professional groups throughout the State. We have continued to act in cooperation with the Georgia Joint Council to Improve the Health Care of the Aged.

It is hoped that there is a greater awareness of the problems facing the private practicing physician in Georgia. In view of the continuing fight it is recommended that the Medical Association of Georgia continue its support of this work.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee recommends approval of this report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the Special Activities Board as recommended by the Reference Committee on motion duly made and seconded.

Woman's Auxiliary to the Medical Association of Georgia

MRS. ENNIS W. WALDEMAYER, *President*

"This learned I from the shadow of a tree, which to
and fro did sway upon a wall,

Our *INFLUENCE* our *SHADOW-SELVES*, may
fall where we can never be."

Influence is such an intangible thing, so hard to measure, but we truly believe the work done this year will permeate into the years that lie ahead and continue to bear fruit.

After we adopted the national motto last May, "Aim for Excellence in Achievement," we went a step further and proclaimed this the "Year of the Counties." County leadership has been magnified; we have sought to come to know each individual president and to view our goals through their eyes. As we have sought to understand their situations, and problems, a wonderful esprit de corps has developed. By convention time I will have met with 38 of the 42 auxiliaries and will continue working toward making it 100 per cent.

Organization

Our goal is to reach 2,000 membership this year. On February 19, 1963, I met in Vidalia to organize the Auxiliary to the Southeast Medical Society with a charter membership of 18. This is an enthusiastic group and they have set out to participate in all phases of the auxiliary work. In early May 1962, I organized the Auxiliary to the Peach Belt Medical Society in Perry with 21 charter members. (This came too late to be included in the 1961-62 Delegates Handbook.)

National

The President and six delegates attended AMA in Chicago in June 1962. At that time International Health Activities was voted a standing committee so Georgia incorporated this committee in our plan of work.

The President and President-Elect, Mrs. John Porter, attended the National Fall Conference in October 1962. At that time the President took part on the National Safety Panel, "Safety from A-Z in Georgia."

State

The summer Executive Board meeting convened in Americus July 18, 19, 1962, with an attendance of 79. The Advisory Committee from the Medical Association of Georgia approved plans of chairmen of standing committees. Printed materials, posters, displays, skits, visual aids of various kinds, and pertinent films were of immeasurable help to county presidents as suggestions for programs and projects.

The winter Executive Board meeting was held January 18, 1963, at the Medical Association of Georgia Headquarters. Seventy-six braved the terrible weather to attend. Reports were given which served as a mid-year inventory. Enough of the calendar year remained for each to go home and act on the information and inspiration received from sharing of ideas.

Community Service

Quickly let me give you a bird's-eye view of the varied projects entered into by the Auxiliary. No space for elaboration, so please read with your imagination!

Staffed fair booth where TB testing was done, skin testing over 500 people; another fair booth (educational in nature) with emphasis on health careers; donated and processed clothing for the Apparel Shop at State Mental Hospital, also gave manpower hours to aid in selection and fitting of clothes for indigent patients; promoted Safety Clinics, Pre-natal Clinics and Colored Nurseries; many took and then taught the Medical Self Help Training Course, one auxiliary taught it to every age group in the community; community survey made, which led the way to establishment of Guidance Clinics for children and adults; Nurse Training Courses given; GEMS, project for baby-sitters continued as fulfilling a read need; new Health Career clubs started, one club won an Award of Distinction from *Parents' Magazine*; radio and chapel programs presented in an attempt to halt the alarming number of "drop-outs." (Use of the "study-buddy" system of help for the first, second, and third grades, which gives the proper background in education.) Auxiliary members contributed their time to tutor these children; invaluable time spent with Senior Citizen Clubs; teen-age driving safety programs continued at request of local judges; layettes provided for indigent patients at several hospitals; funds donated to purchase an approved recording machine and timer to be used in establishing a branch of "recordings for the Blind;" classes in physical fitness sponsored, display on physical fitness set up in city library, lectures given for three consecutive Tuesdays on the following topics, "What Price Fat," "The Tired Body," and the "Role of Physical Fitness and Exercise;" contributions made to hospital library; annual party for practical nurses graduating from Vocational School; assisted at Georgia State Training School for Girls; urged placement of safety-lens in children's eyeglasses; distributed safety brochures, "What to do in an Emergency" through the Welcome Wagon team; worked with Teen-town; Girl Scouts organized in towns without scouting and leadership provided; garden therapy and other ministrations to nursing homes; donated money to school for retarded children; sponsored competitive swim team for youth; new fall-out shelters built.

Other Areas

Some auxiliaries were 100 per cent in contribution to AMA-ERF and nearly all contributed something to this worthy cause. Over \$2,000 has been received at this time but more will be forthcoming.

A fair response has been given to GaMPAC membership but we hope for a larger number as more people are informed of its work.

Stress has been placed on legislation and many have included at least one program or have had an alert chairman who at each meeting brought the group news of legislation affecting the medical profession. Letters and telegrams have been sent at different times vigorously opposing any type Federal financed health plan. A pamphlet, "A Guide for Georgia Voters" was reported on and plans made to distribute one to every member; letters written to respective Senators and Governor Sanders expressing opposition to Senate Bill 35 re: Podiatry being included in Blue Shield Insurance

plans; membership informed of the pamphlet "Your Local Government" which will be off the press soon.

In every community wherever there are needs to be met, there you will find the wives of dedicated doctors, joining hands with others to lift the load; working ultimately toward the betterment of life for all, regardless of race, color or creed.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee unanimously approves and gives great commendation to the Woman's Auxiliary, and to Mrs. Ennis W. Waldemayer, its President, for the support of the profession and for the efforts in their communities and throughout the state.

HOUSE OF DELEGATES ACTION—Adopted the report of the Woman's Auxiliary to MAG as recommended by the Reference Committee on motion duly made and seconded.

Resolution No. 4

AMA COUNCIL ON MEDICAL EDUCATION

LESTER RUMBLE, JR., FULTON COUNTY MEDICAL SOCIETY

Whereas, Resolution No. 6 pertaining to membership in the Council on Medical Education and Hospitals was introduced on the Floor of the House of Delegates at the June 1962 meeting of the AMA and referred to the Reference Committee on Medical Education and Hospitals; (a copy of the resolution and its history taken from the Proceedings of the AMA House of Delegates for the 111th Annual Session, June 24-28, 1962 being attached) and

Whereas, The Reference Committee, after consideration of the intent of Resolution No. 6, submitted a substitute for Resolution No. 6, and

Whereas, The House voted not to adopt this substitute resolution, but voted to refer this portion of the Reference Committee report to the Board of Trustees for study, and

Whereas, The Board of Trustees has let this matter lie dormant for nearly one year; therefore be it

Resolved, That the Medical Association of Georgia instruct its Delegates to the AMA meeting in June 1963 to take the necessary action to bring this Resolution back from the Board of Trustees to the Floor of the House of Delegates.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee approves Resolution No. 4 with commendation and moves that it be accepted.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 4: AMA Council on Medical Education Membership, as recommended by the Reference Committee on motion duly made and seconded.

Resolution No. 6

CIGARETTE SMOKING

JOHN S. ELLIOTT FOR THE GEORGIA MEDICAL SOCIETY

Whereas, the preponderance of the evidence indicates that cigarette smoking is implicated in the genesis of lung cancer and probably other diseases; and

Whereas, the Medical Association of Georgia is concerned in all matters relating to the public health;

Therefore, be it resolved: That the Medical Association of Georgia go on record as advocating the volun-

tary giving up of cigarette smoking by those already habituated; and

Be it further resolved, that the Medical Association of Georgia through an appropriate committee or commission initiate and maintain an educational program designed to inuence young people not to start the habit of smoking.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee recommends that this Resolution be accepted with a change in Paragraph 2 to make it read: "WHEREAS, the Medical Association of Georgia is concerned in all matters relating to the health of the public" (instead of public health) and that a copy of this Resolution be sent to all other state medical associations and that our Delegates to the AMA present this before the AMA House of Delegates at the next meeting.

HOUSE OF DELEGATES ACTION—At this point the Chair recognized Dr. Eustace Allen, Dr. W. P. Kirkland and Dr. J. F. Cantrell who spoke in opposition to this Resolution. Following discussion, the Speaker called for a voice vote. At the request of one of the delegates, a standing vote was granted by the Speaker to approve or disapprove the Resolution and Reference Committee recommendation in favor of the Resolution being adopted. By actual ballot of 27 for and 66 in opposition, the Resolution and Reference Committee Recommendation were declared disapproved.

Supplementary Report of the Committee on Cancer No. A

CANCER SUB-COMMITTEE ACTIVITY

ROBERT C. PENDERGRASS, AMERICUS, *Chairman*

The Sub-Committee on Cancer of the Medical Association of Georgia has held no official meeting. To date no meeting has been requested by Dr. Murphy to whom we act in an advisory capacity.

On April 4, 1963, at a meeting at the Guy T. Bernard Cancer Clinic, Dr. Murphy and Dr. Venable discussed problems with several clinic directors. At this time, Dr. Murphy stated that he believed available funds would be sufficient to operate the program for this year. Dr. Venable gave an outline of the cancer clinic control program and the State Health Department activities. He stated there is little prospect that more funds will become available for the cancer control program.

As a result of this meeting, it was felt that the cancer clinic directors should meet at least once a year and Dr. Brown has offered to arrange such a meeting in Atlanta this fall.

This report was rendered by Dr. Menard Iben, Ex. Director of the Guy T. Bernard Cancer Clinic.

"On April 24, 1963, I received a letter from Dr. Murphy who says it now appears that some reduction in the rate of expenditures will be required during the remainder of the fiscal year which ends June 30th. He requested that the various clinics make every effort to keep costs as low as possible, particularly hospitalization which now accounts for about 85 per cent of the clinic costs. He requested that during the next two months hospital admissions be kept at a minimum.

Sometime ago, Dr. Murphy gave us some figures representing each clinic's share of the current budget. Only a few clinics have exceeded the estimates by any appreciable amount.

It appears that we are faced with the same situation with which we were faced last year.

Dr. James N. Brawner, Chairman of the Mental Health Sub-Committee, has already submitted his report which is published in the Handbook for the House of Delegates." The above material constitutes the report of the Sub-Committee on Cancer.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee accepts and approves this report and suggests that the Sub-Committee on Cancer of the Medical Association of Georgia be instructed to investigate this problem and that the MAG make an effort to get necessary legislation passed to maintain the State Cancer Clinic Program in the future.

HOUSE OF DELEGATES ACTION—Adopted supplementary Report No. A: Cancer Sub-Committee Activity, as recommended by the Reference Committee and the additional recommendation of the Reference Committee on motion duly made and seconded.

It was moved by Chairman of Reference Committee No. 5, Jule C. Neal, Macon, and duly seconded that the report of Reference Committee No. 5 as amended be approved as a whole and it was so ordered.

Speaker Walker then called for unfinished business and there being none, Dr. Walker opened the floor for new business. There being no new business, Speaker Walker entertained a motion for adjournment of the Second Session of the Medical Association of Georgia House of Delegates Meeting in conjunction with the 109th Annual Session of the Association. On motion duly made and seconded the House adjourned at 10:15 p.m.

AMA-ERF CONTRIBUTORS

Name	Address	Name	Address
Brumby, Mrs. O. A.	Marietta, Ga.	Med. Assn., Ga., Wo. Aux.	Georgia
Bulloch Wo. Aux.	Georgia	Muscogee Co. Med. Soc., Wo. Aux. . .	Columbus, Ga.
Cacchiolo, L. G.	Hartwell, Ga.	Pence, Robert	Metter, Ga.
Chattahoochee Wo. Aux.	Duluth, Ga.	Pittman, Carl, Jr.	Tifton, Ga.
Collins, R. A.	Americus, Ga.	Richmond Co. Med. Soc., Wo. Aux. . .	Augusta, Ga.
Collins, R. A., Jr.	Georgia	Robinson, John	Americus, Ga.
Dougherty Wo. Aux.	Albany, Ga.	Robinson, R. S.	Metter, Ga.
Dougherty County Med. Soc. Wo. Aux. .	Albany, Ga.	Schley, Mary W.	Columbus, Ga.
Gatewood, Schley	Albany, Ga.	Smith, Leo	Waycross, Ga.
Griffin, L. H.	Claxton, Ga.	Ware Co. Med. Soc., Wo. Aux.	Waycross, Ga.
Magood, Murl	Marietta, Ga.	Yeomans, Neal	Waycross, Ga.



JEKYLL ISLAND

109th annual session



George R. Dillinger, Thomasville, President-Elect, presents outgoing President, Thomas W. Goodwin of Augusta, with a bound copy of the JOURNAL of MAG.



Visitors view the products and samples of some 52 Commercial Exhibitors in the Exhibition Hall of the Aquarama.

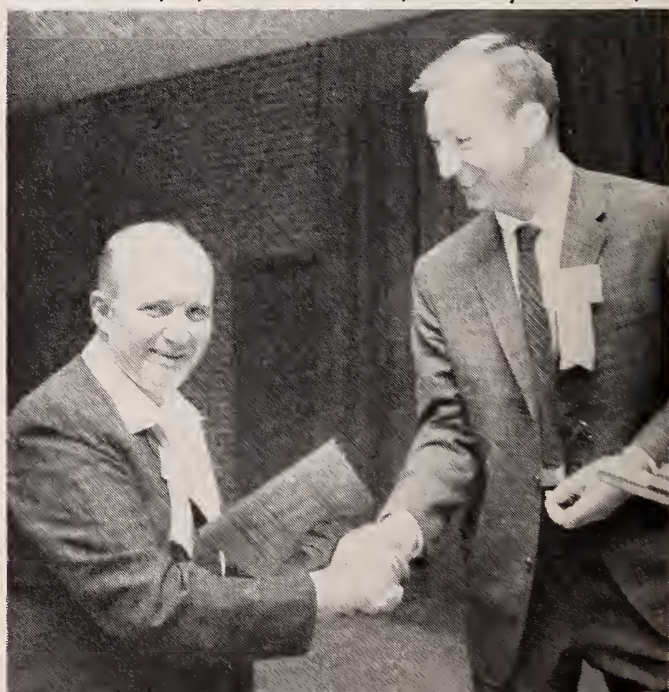


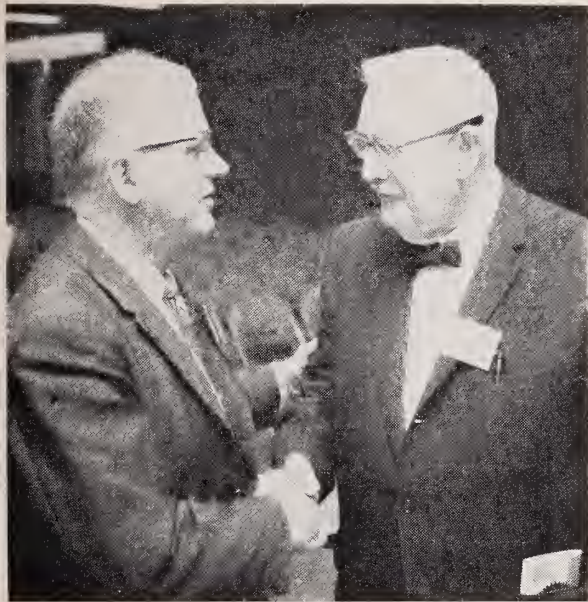
Reference Committee No. 5 meets in the Rotunda of the Aquarama with Jule C. Neal (center) of Macon as Chairman.

Dr. Edgar A. Hines, Jr. of Oteen, N. C. delivers his paper as guest speaker for the Abner W. Calhoun Memorial Lecaureship.



Edgar Grady, Atlanta, Scientific Exhibits Chairman, presents the first prize award to Perrin Nicholson, III, Atlanta, for the winning scientific exhibit, "The Renal Photoscan," made by Dr. Nicholson, Ernest G. Smith, Jr., Samuel S. Ambrose, and Henry C. Johnson, Jr.





GP of the Year Awardee, James C. Anderson of Macon, (right) is congratulated by George Alexander of Forsyth, who presented the award to Dr. Anderson.



Dr. Dillinger presents a Certificate of Appreciation to Mr. Tom Hendricks of the American Medical Association for his devotion and service rendered in the past years to the Medical Association of Georgia.



Dr. Charles T. Cowart, LaGrange, (far left) turns from the popular Coca-Cola exhibit to view some of the remaining 52 Commercial Exhibits.



The large group of Reference Committee No. 4 discusses pertinent issues concerning the policies of the Association.

GaMPAC breakfast guest speaker, Domingo Camacho, Savannah, (second from right) poses with GaMPAC officers and supporters (left to right) John T. Mauldin, Atlanta; Milford B. Hatcher, Macon; and W. W. Osborne, Savannah.



Mrs. Ennis W. Waldemayer, Americus, outgoing President of the Woman's Auxiliary, smiles despite a broken foot and is cheered and congratulated by her husband, Ennis Waldemayer, and Dr. Goodwin.



MAG GENERAL BUSINESS SESSION

109TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

SUNDAY, MAY 5, 1963

THE FIRST GENERAL BUSINESS SESSION of the 109th Annual Session of the Medical Association of Georgia was called to order by President Thomas Goodwin, Augusta, at 2:05 p.m. in the Aquarama Meeting Room, Jekyll Island, Georgia, on May 5, 1963.

President Goodwin stated that the purpose of this first General Business Session was the nomination of officers, councilors, AMA delegate and alternate delegate and a nomination for the Association "General Practitioner of the Year Award" and the "Hardman Award." Dr. Goodwin appointed a Tellers Committee as follows: Dr. Fred Simonton, Chickamauga, Chairman, and Dr. Milford Hatcher, Macon, and Dr. Luther Wolff, Columbus as members of the Tellers Committee. Dr. Goodwin announced that the hours for balloting on nominations made at this meeting were as follows: May 5—2:30 p.m. to 5:00 p.m.; May 6—9:00 a.m. to 1:00 p.m.; and May 7—9:00 a.m. to 5:00 p.m.; at which time the ballot box would officially close.

President Goodwin then called for nominations from the floor for Association officers and the following nominations were made:

Nominations

President-Elect—J. G. McDaniel, Atlanta; nominated by Linton Bishop, Atlanta; seconded by David R. Thomas, Jr., Augusta, Walter Brown, Savannah, and T. A. Peterson, Savannah.

There being no other nominations for the office of President-Elect, it was duly moved and seconded that nominations be closed and President Goodwin instructed the Secretary to cast a unanimous ballot for J. G. McDaniel as President-Elect of the Medical Association of Georgia.

Second Vice President—Kirk Train, Jr., Savannah; nominated by Walter Brown, Savannah; seconded by Lloyd Osteen, Savannah, Leonard Rabhan, Savannah, and John Elliott, Savannah.

There being no other nominations for the office of Second Vice President, on motion duly made and seconded, the nominations were closed and President Goodwin instructed the Secretary to cast a unanimous ballot for Kirk Train, Jr. as Second Vice President of the Medical Association of Georgia.

Secretary—John T. Mauldin, Atlanta; nominated by Joseph Mercer, Brunswick; seconded by George Alexander, Forsyth, and Fred Simonton, Chickamauga.

There being no other nominations for the office of

Secretary, on motion duly made and seconded, it was voted that the nominations be closed and President Goodwin instructed the Secretary to cast a unanimous ballot for John T. Mauldin as Secretary of the Medical Association of Georgia for a three year term of office.

President Goodwin then referred to Chapter V, Section 2 of the MAG Constitution and Bylaws as follows: "Nominations for Councilors and Vice Councilors shall be made by each district society at its annual meeting and forwarded by its secretary to the Secretary of the Association not later than 15 days before the Annual Session. If no nomination is presented by a district society for county medical societies having 100 or more active members which are entitled to elect one Councilor and one Vice Councilor directly representing their society shall be forwarded in like manner as a district society for election by ballot by the members of the Association during the Annual Session."

President Goodwin then read the nominations as received at least 15 days prior to the convening of this Annual Session from the 9th District Medical Society, 10th District Medical Society, Richmond County Medical Society, Bibb County Medical Society, and the Fulton County Medical Society. The following nominations were then read:

Ninth District Councilor (1966)—Charles Andrews, Canton.

Ninth District Vice Councilor (1966)—Paul T. Scoggins, Commerce.

Tenth District Councilor (1966)—A. W. Simpson, Washington.

Tenth District Vice Councilor (1966)—Marion Hubert, Athens.

Richmond County Medical Society Councilor (1966)—Harry Pinson, Augusta.

Richmond County Medical Society Vice Councilor (1966)—Joseph L. Mulherin, Augusta.

Bibb County Medical Society Councilor (1966)—George Alexander, Forsyth.

Bibb County Medical Society Vice Councilor (1966)—W. H. M. Weaver, Macon.

Fulton County Medical Society Councilor (1966)—Charles Jones, Atlanta.

Fulton County Medical Society Vice Councilor (1966)—Linton Bishop, Atlanta.

President Goodwin then stated under the authority of the Constitution and Bylaws, he would instruct the MAG Secretary to cast a ballot in behalf of the membership for these nominations as presented by their respective District and County Medical Societies and thereby declare the nominees so elected.

AMA Delegate (term beginning January 1, 1964)—J. W. Chambers, LaGrange; nominated by Joseph Mercer, Brunswick; seconded by Eustace Allen, Atlanta.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations and President Goodwin instructed the Secretary to cast a unanimous ballot for the election of J. W. Chambers, LaGrange, as AMA Delegate.

AMA Alternate Delegate (term beginning January 1, 1964)—George Dillinger, Thomasville; nominated by A. G. Leroy, Thomson; seconded by David R. Thomas, Jr., Augusta.

There being no other nominations, on motion duly made and seconded, it was voted to close the nominations and President Goodwin instructed the Secretary to cast a unanimous ballot for the election of George Dillinger, Thomasville, as AMA Alternate Delegate.

At this time, President Goodwin then stated that there were no contested offices and that the Tellers Committee need not conduct general balloting for Association Officers.

GP of the Year Award

President Goodwin called for nominations for the "General Practitioner of the Year Award." The following nomination was made:

James Clack Anderson, Macon; nominated by the Bibb County Medical Society and duly seconded.

There being no other nominations, on motion duly made and seconded it was moved that the nominations be closed and President Goodwin informed the membership that this nomination would be presented to the MAG House of Delegates meeting later that day to elect the GP of the Year Award recipient.

Hardman Award

President Goodwin called for nominations for the Hardman Award and the following nominations were received.

(1) Medical staff of Battey State Hospital; nominated by the Floyd County Medical Society and duly seconded.

(2) Richard Torpin, Augusta; nominated by the Richmond County Medical Society and duly seconded.

There being no further nominations, on motion duly made and seconded it was voted that nominations be closed and President Goodwin informed the general membership that these nominations were to be considered by a secret committee and the award would be made at the final General Business Session.

There being no further business, the first General Business Session of the 109th Annual Session of the Medical Association of Georgia was recessed at 2:40 p.m.

MAG GENERAL BUSINESS SESSION (Second Session)

109TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

MONDAY, MAY 6, 1963

THE SECOND GENERAL BUSINESS SESSION of the 109th Annual Session of the Medical Association of Georgia was called to order by President Thomas Goodwin, Augusta at 12:30 p.m. in the Aquarama Meeting Room, Jekyll Island, Georgia, on Monday, May 6, 1963.

The invocation was given by the Rev. Talbert Morgan, St. Marks Episcopal Church, Brunswick, Georgia.

A word of welcome was given by Dr. Ben T. Galloway, President of the Glynn County Medical Society, in behalf of the membership of the Society who were hosts for this 109th Annual Session.

The Honorable W. H. Sigman, Mayor of the City of Brunswick, welcomed the Medical Association of Georgia membership and their wives and guests to Jekyll Island on the occasion of this meeting.

President Goodwin then turned over the gavel to First Vice President Lee Battle, Rome, who then presided. Dr. Battle introduced President Thomas Goodwin who addressed the membership on the subject: "Report of the Presidential Year, 1962-63." On the completion of the President's speech, Dr. Goodwin again assumed the duties of presiding officer.

President Goodwin then introduced President-Elect George Dillinger, who presented an address to the Association membership on the subject: "Our Association's Future for 1963-1964."

Upon completion of the address by President-Elect George Dillinger, President Goodwin recessed the second General Business Session of the 109th Annual Session of the Medical Association of Georgia at 1:05 p.m.

MAG GENERAL BUSINESS SESSION (Third Session)

109TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

WEDNESDAY, MAY 8, 1963

THE THIRD GENERAL BUSINESS SESSION of the 109th Annual Session of the Medical Association of Georgia was called to order by President Thomas Goodwin, Augusta, at 11:00 a.m. in the Aquarama Meeting Room, Jekyll Island, Georgia, Wednesday, May 8, 1963.

Fifty-Year Certificates

President Goodwin called on Immediate Past-President Fred Simonton, Chickamauga, who presented the Fifty-Year Certificates and Pins to physician members who have practiced medicine for 50 years or more. These presentations were made to the following physicians: Robert H. Bradley, Chatsworth; R. Thornton Camp, Fairburn; Ernest Stewart Colvin, Atlanta; Charles Henry Dickens, Madison; Ward Beecher Duvall, Atlanta; Thomas Mixon Ezard, Roswell; Kimsey E. Foster, (Deceased), College Park; Thomas Pope Goodwyn, Atlanta; John H. Grubbs, Molena; William Arthur Hodges, Atlanta; Cornelius F. Holton, (Deceased), Savannah; Arthur L. Horton, (Deceased), Cartersville; Albert Sidney Johnson, Sr., Elberton; O. F. Keen, Macon; Fleming D. Kennedy, Baxley; Harry Nelson Kraft, Atlanta; C. J. Maloy, McRae; Robert H. McDonald, Newnan; Joseph Eugene Mercer, Vidalia; Mark P. Pentecost, Marietta; Carl S. Pittman, Sr., Tifton; DeWitt W. Pritchett, (Deceased), Barnesville; Willis Eugene Ragan, Atlanta; George A. Ward, (Deceased), Elberton; and L. Earl Williams, Cordele.

Scientific Exhibits Awards

President Goodwin called on Edgar Grady, Atlanta, Chairman of the Association Scientific Exhibit Awards Committee who made the following presentations:

First Place Award—"The Renal Photoscan"—

Ernest G. Smith, Jr., M.D.; Samuel A. Ambrose, M.D.; Henry C. Johnson, Jr., M.D., and William Perrin Nicholson, III, M.D., Atlanta, Georgia.

Second Place Award—"Intra-Arterial Fluorescein as an Adjunct in Evaluation of Peripheral Arterial Disease"—

Kermit Lowry, M.D.; James F. Kirkpatrick, M.D., and J. C. Thoroughman, M.D., Veterans Administration Hospital, Atlanta, Georgia.

Third Place Award—"Mammography"—

James V. Rogers, Jr., M.D., and R. Waldo Powell, M.D., Atlanta, Georgia.

GP of the Year Award

President Goodwin called on George Alexander, Forsyth, Past President of the Georgia Academy of General Practice to present the GP of the Year Award. Dr. Alexander presented the "General Practitioner of the Year Award" to James C. Anderson, Macon.

MAG Certificates of Appreciation

President Goodwin requested John T. Mauldin, Atlanta, Secretary of the Medical Association of Georgia, to present the following Certificates of Appreciation. Dr. Mauldin then presented these Certificates of Appreciation in behalf of MAG: Thomas Goodwin, Augusta, for service as President of the Medical Association of Georgia; J. G. McDaniel, Atlanta, for service as Councilor from the Fifth District and the Fulton County Medical Society; George Alexander, Forsyth, for service as Chairman of MAG Council; Eustace A. Allen, Atlanta, for service as American Medical Association Vice President; Lee Battle, Jr., Rome, for service as MAG First Vice President; August Yochem, Atlanta, for service as Chairman of the MAG Weekly Health Column Committee; Helen Bellhouse, Atlanta, for service as Secretary of the MAG Maternal and Infant Welfare Committee; Joseph Stetler, Chicago, for service to the American Medical Association and MAG as Director of the AMA Socio-Economic Division; Thomas Hendricks, Chicago, for service to AMA as Assistant to the AMA Executive Vice President; and Mrs. Ennis Waldemayer, Americus, for service as President of the Woman's Auxiliary to MAG.

Hardman Award

President Goodwin called on President-Elect George Dillinger, Thomasville, to present the Hardman Award Certificate and Cup. President-Elect Dillinger then presented the Hardman Award Certificate and Cup to Dr. Richard Torpin of Augusta.

Distinguished Service Award

President Goodwin then reported that the Distinguished Service Award Committee had chosen

G. Lomard Kelly of Augusta, to receive this high honor and the award was so presented.

Site of 1965 Annual Session

President Goodwin announced that the site for the 1964 MAG Annual Session had been previously set as Macon, Georgia, on invitation of the Bibb County Medical Society. He then called for invitations to MAG to convene the 1965 Annual Session. Preston Ellington, Augusta, President of the Richmond County Medical Society invited the Association to hold its 1965 meeting in Augusta and the invitation was unanimously accepted.

Election Results

President Goodwin stated that as none of the elective offices of the Association were contested, and as he had instructed the Secretary of the Association to cast a unanimous ballot electing those nominees made at the first General Business Session held May 5, 1963, that the Tellers Committee report that this had been done, and accordingly these nominees be so elected.

Installation of Officers

The next order of business was the installation of the 1963-64 Officers and Councilors as follows:

- President*—George Dillinger, Thomasville (1964).
- President-Elect*—J. G. McDaniel, Atlanta (1964).
- Immediate Past President*—Thomas Goodwin, Augusta (1964).
- First Vice President*—Walker Curtis, College Park (1964).
- Second Vice President*—Kirk Train, Jr., Savannah (1964).
- Secretary*—John T. Mauldin, Atlanta (1966).
- AMA Delegate*—(term beginning January 1, 1964)—J. W. Chambers, LaGrange (December 30, 1966).
- AMA Alternate Delegate*—(term beginning January 1, 1964)—George Dillinger, Thomasville (December 30, 1966).

MAG SOCIETY MEMBERS APPOINTED TO WORKMEN'S COMPENSATION MEDICAL BOARD

The following physicians, approved by the Medical Association of Georgia, were recently appointed by Governor Carl Sanders to the Workmen's Compensation Medical Board:

Dr. David L. Hearin, graduate in 1943 of Medical College of Georgia; has practiced in Atlanta twelve years, specializing in Dermatology. Postgraduate work was done at the University of Pennsylvania; served as a Lieutenant in the United States Navy, World War II. Dr. Hearin was certified by the American Board of Dermatology in 1951.

Dr. William C. Coles, graduate of Emory University

Ninth District Councilor—Charles Andrews, Canton (1966).

Ninth District Vice Councilor—Paul T. Scoggins, Commerce (1966).

Tenth District Councilor—A. W. Simpson, Washington (1966).

Tenth District Vice Councilor—Marion Hubert, Athens (1966).

Richmond County Councilor—Harry Pinson, Augusta (1966).

Richmond County Vice Councilor—Joseph L. Mulherin, Augusta (1966).

Bibb County Councilor—George Alexander, Forsyth (1966).

Bibb County Vice Councilor—W. H. M. Weaver, Macon (1966).

Fulton County Councilor—Charles Jones, Atlanta (1966).

Fulton County Vice Councilor—Linton Bishop, Atlanta (1966).

Immediate Past President Thomas Goodwin then turned the gavel over to President George Dillinger.

At this time, President Dillinger presented Immediate Past President Goodwin with a token of the Association's appreciation for Dr. Goodwin's service as MAG President. Dr. Dillinger gave President Goodwin the President's Key and a bound copy of the *Journal of the Medical Association of Georgia* published during the term of office of former President Goodwin.

Official Attendance Records

President Dillinger announced that a compilation of the official attendance at the 109th Annual Session of the Medical Association of Georgia held on Jekyll Island, May 5-8, 1963, was as follows: MAG members—642; other physicians registered—56; Association guests—78; and exhibitors registered—118; thereby making a grand total of 894 registrants.

There being no further business, President Dillinger adjourned the 109th Annual Session of the Medical Association of Georgia held at the Aquarama, Jekyll Island, Georgia, May 5-8, 1963, at 12:00 noon.

School of Medicine, 1939, has practiced Radiology in Atlanta for twelve years. Graduate work was done at the Massachusetts General Hospital, Boston, Mass., 1946 and 1947, and at St. Joseph's Infirmary in Atlanta. He was a Diplomate of the American Board of Radiology, 1947, and was a Major in the United States Army, World War II.

Dr. Jack C. Norris, a longtime member of the Board, will succeed Dr. Hugh Hailey as Chairman.

Reprint from *The Bulletin of the Fulton County Medical Society*, Vol. 37, No. 3, 1963.

1963-64 CALENDAR OF MEETINGS

State

September 20-21—Georgia Heart Association, Fifteenth Annual Meeting and Scientific Sessions, Biltmore Hotel, Atlanta.

September 30-October 4—"Five Days of Internal Medicine," sponsored by the Department of Medicine, Emory University School of Medicine, Atlanta.

October 17-19—Emory Postgraduate Seminar in Gynecology and Obstetrics offered by the Department of Gynecology and Obstetrics, Emory University School of Medicine, Atlanta.

May 3-6, 1964—110th Annual Session of the Medical Association of Georgia, Macon, Ga.

Regional

June 24-27—American Orthopedic Association, The Homestead, Hot Springs, Va.

July 15-20—Duke Medical Postgraduate Course, Morehead-Biltmore Hotel, Morehead City, N. C.

July 17-19—Third Annual Dixie Postgraduate Assembly, Birmingham, Ala.

August 22-24—Sixteenth Annual Postgraduate Obstetric-Pediatric Seminar sponsored by Children's Bureau and the state health departments of Georgia, South Carolina, Mississippi, Alabama, and Florida, Riviera Beach Motel, Daytona Beach, Fla.

September 5-7—American Association of Obstetricians and Gynecologists, The Homestead, Hot Springs, Va.

September 30-October 1—Tennessee Valley Medical Assembly, Read House, Chattanooga, Tenn.

October 6-9—Medical Society of Virginia, Roanoke Hotel, Roanoke, Va.

October 10-13—American Society of Maxillofacial Surgeons, Sheraton-Park Hotel, Washington, D. C.

October 13-18—International Congress of Plastic Surgery, Sheraton-Park Hotel, Washington, D. C.

October 14-18—Postgraduate course sponsored by the American College of Chest Physicians on Recent Advances in the Diagnosis and Treatment of Disease of the Heart and Lungs, Washington, D. C.

October 20-23—American College of Gastroenterology, Shoreham Hotel, Washington, D. C.

October 27—Association of Clinical Scientists, Statler-Hilton Hotel, Washington, D. C.

November 7-9—Conference on Obstetric, Gynecologic, and Neonatal Nursing sponsored by District Four, Washington, D. C.

November 8-9—Southern Society for Pediatric Research, St. Jude Hospital, Memphis, Tenn.

November 18-21—Southern Medical Association, New Orleans, La.

National

June 16-20—American Medical Association Annual Meeting, Atlantic City, N. J.

July 15-19—Second International Conference on Congenital Malformations sponsored by the National Foundation-March of Dimes, Americana Hotel, New York City.

August 26—Annual Meeting of the American Academy of Physical Medicine and Rehabilitation, Sheraton-Dallas Hotel, Dallas, Tex.

September 15, 1963-June 15, 1964—Nine month tutorial program in Cardiology offered by the Institute for CardioPulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

September 16-28—Postgraduate course in Laryngology and Bronchoesophagology sponsored by the Department of Otolaryngology, University of Illinois College of Medicine.

October 5-11—Annual Otolaryngologic Assembly sponsored by the Department of Otolaryngology of the University of Illinois College of Medicine and the Illinois Eye and Ear Infirmary.

October 11-15—Eighth International Congress on Diseases of the Chest sponsored by the Council on International Affairs of the American College of Chest Physicians, Mexico City, Mex.

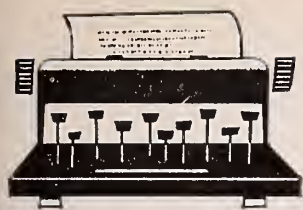
October 17-19—Clinical Neuropsychiatric Association, Sheraton-Lincoln Hotel, Houston, Tex.

October 21-22—American Cancer Society, Scientific Session, Conference on Unusual Forms and Aspects of Cancer in Man, Biltmore Hotel, New York City.

October 21-25—Postgraduate course sponsored by the American College of Physicians on Clinical Cardio-pulmonary Physiology, Chicago, Ill.

November 11-15—Postgraduate course sponsored by the American College of Chest Physicians on Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, New York City.

November 30-December 1—Interim Clinical Meeting, American College of Chest Physicians, Portland, Ore.



Measles Immunization

IN THIS AGE of antibiotics and chemotherapeutic agents the pendulum appears to be swinging in the direction of increasing breakthroughs in the immunological area. Now a promising vaccine, effective against measles, has become available to physicians. This major advance in preventive medicine utilizes the live attenuated virus and the inactivated or "killed" virus vaccine.

Widespread Interest

Because of increasing evidence of serious complications associated with measles, the vaccine should generate widespread interest especially among those physicians charged with the care of our younger age groups. Since we now have what appears to be an effective tool against this widespread disease, it is our responsibility as physicians to educate the parents of susceptible individuals regarding the potential seriousness of the disease. Few physicians, not to mention parents, realize that the total measles mortality now exceeds that of poliomyelitis. We need to be reminded that encephalitis with its attendant high mortality and morbidity develops in about one in 1000 children with unmodified measles. In natural measles 50 per cent of patients will show significant electroencephalographic changes. Following clinical recovery from established cases of measles encephalitis, the electroencephalograms generally return to normal limits. In spite of this, it has still been shown in a considerable number of cases, that there is clear evidence from readily applied psychologic tests that the level of intelligence has been depressed by the disease.

In addition to this, in measles, the risk of secondary bacterial infection is high and although rarely life threatening, these complications are attended by a great deal of distress and occasionally permanent sequelae.

Because of the obvious seriousness of the disease, the administration of the measles vaccine is desirable

in all children over nine months of age who have not had measles. It is particularly indicated for children under three, and for those with chronic illness, in whom complications could be very serious. Since most adults are immune, it does not, at present, seem advisable to routinely administer the vaccine to this age group. However, it may be advisable to give the vaccine to young adults and older children who cannot establish a history of measles.

Since several programs for immunization have been proposed utilizing both live virus and killed virus, the ultimate effectiveness of each program must await long term usage. At this time only the live attenuated virus vaccine is available and may be used either alone or in conjunction with immune globulin to reduce the severity of the febrile reaction. It is important to give no more than the recommended dose of gamma globulin to prevent significant interference with the immune reaction. Some consultants have advised the use of gamma globulin only in chronically ill or debilitated children. If a susceptible child has been exposed to measles, vaccination can be effective if given within the first 24 to 48 hours after exposure.

Contraindications

In spite of all the enumerated advantages of the live vaccine now available, there are definite contraindications to its usage. These contraindications are: pregnancy, leukemia, and other generalized malignancies; therapy which depresses resistance, such as steroids, irradiation, alkylating agents, and anti-metabolites; severe febrile illness; gamma globulin administered within the preceding six weeks; and marked sensitivity to egg.

Before employing any measles vaccine, physicians should read the manufacturer's package insert, as well as the statement of the advisory committee of the United States Public Health Service (mailed to all U.S. physicians; also published in J.A.M.A., 183: 1112, 1963).

Between a Rock and a Hard Place

THE GEORGIA MEDICAL POLITICAL ACTION COMMITTEE celebrated its first birthday last month with a whopping-big breakfast meeting on Jekyll Island. Running apart from but concurrent with the 109th Annual Session of MAG, GaMPAC assembled a "full house" gathering of its own members and other interested guests for a 7:30 a.m. breakfast.

The featured speaker for the occasion was Mr. Domingo Camacho, a refugee from Cuban Communism and at present a practicing attorney in Savannah. Speaking to an overflow crowd, Mr. Camacho detailed before his enthusiastic audience the gradual, step-by-step take-over of the Cuban government by dedicated red agents.

While GaMPAC is not per se an anti-communist organization, Mr. Camacho's remarks were nonetheless appropriate as part of GaMPAC's continuing education program for its members in all phases of political action.

Impressive Gains

After one year of operation GaMPAC can cite impressive gains in organization, membership and activities. Exactly one year ago your *Journal* commented editorially that GaMPAC, a new political entity, had emerged on the Georgia political scene. The need for such an organization was apparent then and is doubly apparent today. For the past 30 years the United States has been involved in an oblique revolution. The effect of this revolution has been to alter our government and our national character from one where self reliance, free enterprise and constitutional government were considered bedrock virtues to one where dependence, excessive governmental regulation and executive order rule supreme.

GaMPAC is dedicated to putting the brakes on this type of revolutionary upheaval. It believes that the best and perhaps the only way this can be accomplished is through increased political activity by those willing to take a positive stand against such activities.

Notwithstanding the progress GaMPAC has made, there still persists among us those who view with skepticism and apathy any organized effort to plunge full length into the fight to preserve our heritage and our institutions. Frankly, it is beyond us how anyone could turn over, as a bare minimum, 20 per cent of his income in Federal taxes and then piously

confess that what this government does with his money is somehow none of his business. Government is your business, because you are the government. Government derives its power from the consent of the governed and no one can deny that we are among the most governed peoples on this earth.

Selection Via GaMPAC

It follows then, rather logically we believe, that you have no alternative but to become active in the selection of these people who shall govern you.

This is where GaMPAC gets into the act. As individuals, ours is but a voice crying in the wilderness. Collectively we can exert great influence in the selection and election of those candidates for public office who in turn exercise great influence over our lives and our profession.

GaMPAC's objective is good government. It is neither a Democrat nor Republican organization. Rather, it is an organization dedicated solely to the election of those persons whose talent and philosophy are in practical alignment with our own.

Political campaigns mean three things: Organization, Money and Manpower. The bigger and better our organization, the bigger our campaign coffers and the larger manpower pool, the greater our chances for success.

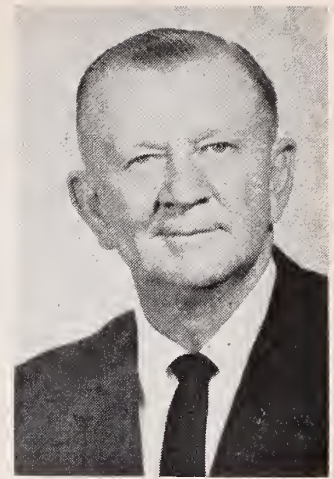
Not From the Sidelines

As stated in previous editorials, MAG cannot participate directly in political activities. It can do nothing but watch from the sidelines even while candidates for public office openly advocate principles and programs designed to wreck the profession. This puts the average medical practitioner squarely between a rock and a hard place with nowhere to turn but organization outside his professional association. No other political organization has GaMPAC's point of view because no other group has been organized for doctors. The sad truth of the matter is that no other professional or business group has organized for the purpose of exerting influence in the election of responsible candidates for high office. This is not the first time medicine has led the pack for the restoration of good order. It surely won't be the last.

If you have not already done so, contact the GaMPAC representative in your District and make plans to become affiliated with GaMPAC at your first opportunity. GaMPAC needs you. And the profession needs GaMPAC.

POLITICS AND MEDICINE

GEORGE R. DILLINGER, M.D.



THIS IS MY FIRST REPORT to you as President of the MAG. I have recently returned from Chicago, where I attended the National Medical Legislative Conference.

Doctors have always preferred to be let alone to practice Medicine. They desire to have little or nothing to do with Politics. Politics, however, will not let the physician alone. We are faced with the same recurring problem, Medical Care under Social Security.

The "Socialist" planners who dominate the present Washington scene, want only to get medical care under Social Security. The President of the United States is pledged to the support of this program. "Fedicare" is perhaps the best term to use in describing the present "King-Anderson" Bills before Congress. H. R. 3920 or S. 880 are identical bills. Their enactment would make the Secretary of Health, Education and Welfare, the ultimate "Dictator" of every hospital in the nation. He would say when a patient was admitted, what treatment the patient could receive, and when the patient should be dismissed. He would say even what medicines the patient might receive, or what operation was necessary.

Every physician must read and understand H. R. 3920 or S. 880. The bill is entitled "Hospital Insurance Act of 1963." Every physician must do the following:

1. Inform every patient what the enactment of this legislation would do to Medical Practice.
2. Inform everyone what this would cost the employed people in taxes. (In Georgia, the people working would pay \$23,600,000.00 in additional taxes in 1965. In the U. S., \$2,101,-100,000.00 in additional taxes.) This is only the first year. By 1968 each employee and employer would pay \$253.50; or a total of \$554.00; individuals would pay \$379.60 in

Social Security taxes. This would be the cost to every working man or woman with an income of \$5,200.00 a year.

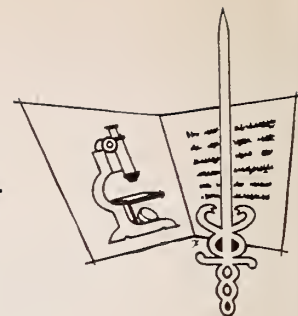
3. Keep every friend, patient, and physician writing to your Congressmen and Senators. Let them know that you are opposed to "Fedicare" H. R. 3920 or S. 880.
4. Support the American Medical Education and Research Foundation, AMA-ERF.
5. Join and support Georgia Medical Political Action Committee (GaMPAC) and American Medical Political Action Committee (AMPAC).
6. Get acquainted with your local political parties, and participate in their activities. Every precinct, Militis District, Ward, County and Congressional District needs local workers, and they need funds to work with.
7. Know the candidates for office before they are elected.
8. Support the establishment of an M.A.A. (Medical Assistance to the Aged) program for the State of Georgia. Inform the Governor of the need for M.A.A.

It will require the help of everyone to keep the control of medical practice in our own state and local communities.

Edmund Burke, the great English statesman and orator, stated nearly 200 years ago, "The only thing necessary for the triumph of evil is that good men do nothing."

A handwritten signature in dark ink, appearing to read "George R. Dillinger". The signature is fluid and cursive, with a large, stylized "G" and "D".

President, Medical Association of Georgia



ENZYMES AND CANCER DIAGNOSIS

John T. Galambos, M.D., *Atlanta*

THE MAJORITY OF CHEMICAL transformations in the human body are reactions affected by organic catalysts called enzymes. A normal living organism is an orderly, integrated succession of enzyme reactions. Enzymes are classified on the basis of the particular chemical reaction in which they participate. For example, an enzyme which splits phosphate off molecules is a phosphatase; if this enzyme performs its action optimally in an acid media it is called an acid phosphatase; or if its optimum activity is in an alkaline media, then it is an alkaline phosphatase. These are non-specific phosphatases. If the enzyme hydrolyzes phosphate off only of certain specific molecules, like adenosine triphosphate (ATP), then it is called ATP-ase. These enzymes which perform the same catalytic activity may be manufactured by several different organs, but they may be separated from each other, for example, by electrophoresis. These are called iso-enzymes. In another way enzymes performing the same catalytic action may be differentiated by the potentiating or inhibitory effects of trace elements or other compounds added to the reaction mixture; for example, the plasma of acid phosphatase of prostatic origin is inhibited by 0.02 M L(+) tartaric acid, but two per cent formaldehyde or 0.001 M cupric sulfate has little, if any, effect; the latter two compounds inhibit acid phosphatase from erythrocyte and from other tissues, but tartrate does not.

Identifications

About 700 enzymes have been identified in human, animal, plant and microbial organisms, but little over ten per cent of these enzymes have been isolated as crystallin proteins. The measurement of "enzymes" in clinical medicine is a measurement of the rate of reaction in which the enzyme participates

and is not a determination of the enzyme protein itself. Therefore, one should talk about enzyme activity and not enzyme levels. Many enzyme catalyzed reactions require in addition to the substrate and enzyme also some other substance or co-factor in relatively low concentrations. Also the enzyme reactions may require an "activator" which is often a metal ion or some small, non-specific organic molecule. The term "co-enzyme" is reserved for specific organic molecules which play a part in the reaction itself, often as carriers of some chemical grouping. When the co-enzyme is firmly attached to the enzyme protein itself, it is called the "prosthetic group." While enzyme activators are usually metallic cations, several enzymes have been shown to be activated by some anions also. For example, amylase is activated by chloride. The activity of an enzyme, therefore, may be measured by determining—directly or indirectly—the amount of substrate changed per unit time. The interpreter of serum enzyme activities must take into account that the stability of the various enzymes varies widely both at room temperature and also at refrigerator or deep freeze temperature.

Well-defined Methods

It would be desirable to have well-defined methods which would differentiate a specific iso-enzyme coming from a particular type of malignant tissue. The detection of this iso-enzyme, then, would be diagnostic of a particular type of cancer, whether it is a primary carcinoma or whether it is a recurrence or metastases. To date, some cancers like the carcinoma of the prostate is associated with a diagnostic increase of a certain kind of acid phosphatase. One must, however, realize that a general elevation of serum acid phosphatase is not necessarily diagnostic of prostatic cancer. The activity of this enzyme in the serum has been shown to be diagnostically elevated in patients with thrombophlebitis, pulmonary

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embolism, myocardial infarction, Gaucher's disease, multiple myeloma, etc. The determination of tartrate-labile acid phosphatase is of more specific value in this respect. Active work is being done in the field of finding changes in serum iso-enzyme activity which would be diagnostic of certain types of cancer.

LDH Determination

The determination of lactic dehydrogenase (LDH) activity may be of use in the differential diagnosis of effusions of the peritoneal or pleural cavity when one compares the serum LDH activity with that of the effusion. Malignant effusions, in general, tended to have a higher LDH activity than the simultaneously obtained serum, while non-malignant effusions had the same or lower LDH activity. This increased effusion/serum LDH ratio was found in 57 to 82 per cent of malignant effusions, but also in 0 to 20 per cent of "benign" effusions. While the beta glucuronidase activity in carcinomatous ascites is statistically higher than in ascites due to cirrhosis or congestive heart failure, it is not diagnostically elevated in the former. In the study of leucine amino peptidase activity of ascitic fluid, it was found that this activity exceeded 95 units in almost two thirds of the cancerous ascites but was less than 95 units in the ascite fluids obtained from patients who did not have cancer.

In normal individuals, the serum enzyme activities are relatively constant. In contrast, cancer patients' serum enzyme activity may be quite variable. In the experimental animal, five to tenfold elevations of LDH activity is detectable before any appreciable growth of the implanted tumor is observed. The successful use of cancer therapeutic agents associated with a decrease of the metastatic tumor masses may be associated with a decrease of several serum enzyme activities. However, tumor regression or progression is not regularly associated with changes of serum enzyme activities. Some authors reported good correlation between the size of the tumor and the elevation of serum LDH activity.

Secondary Effects

Enzyme elevations may be associated with secondary effects of cancer; for example, cancer which would obstruct bile flow would result in elevation of serum alkaline phosphatase, a ATP-ase, 5-nucleotidase or leucine amino peptidase activities. This obstruction doesn't necessarily have to be severe enough to produce jaundice. Cancer involving bone may result in elevation of serum alkaline phosphatase activities. These findings are not specific of cancer. Current work on iso-enzymes may provide clinically useful diagnostic tests for cancer.

69 Butler Street, S.E.

Approved by Professional Education Committee, Georgia Division, ACS.

AMA NAMES NEW GENERAL COUNSEL

Robert B. Throckmorton of Des Moines, Iowa, today was named general counsel of the American Medical Association, effective July 1, 1963.

Dr. F. J. L. Blasingame, executive vice president of the AMA, said Throckmorton will succeed C. Joseph Stetler, who resigned to become executive vice president and general counsel of the Pharmaceutical Manufacturers Association in Washington, D. C. on July 1.

Des Moines Law Firm

Throckmorton, 47, is a member of the Des Moines law firm of Dickinson, Throckmorton, Parker, Mannheimer and Raife. He has been counsel for the Iowa Medical Society since 1955.

In announcing the appointment, Dr. Blasingame said: "The American Medical Association is gratified that we are obtaining the services of a man with wide experience and excellent capabilities to fill the post so ably administered during the past 12 years by Mr. Stetler. Mr. Throckmorton is highly respected by both the medical and legal professions."

A native of Iowa, Throckmorton is a trustee of Drake University, a former chairman of the faculty and lecturer in taxation at Drake Law School.

From 1939-1942, he was in the solicitor's office of the U. S. Department of Agriculture and the following two years served as project attorney for the War Relocation Authority.

Throckmorton received his A.B. degree from Drake University in 1936, his LL.B. from Drake Law School in 1938, and his LL.M. from Harvard Law School in 1939. He was admitted to the bar of Iowa in 1938, and is a member of the Iowa State and American Bar Associations and the American Law Institute.

During World War II he served in the U. S. Navy as a supply and disbursing officer aboard a destroyer.

Throckmorton's father was a physician and served as secretary of the Iowa Medical Society. His grandfather was a country doctor in Iowa, and his brother, Tom, is a surgeon in Des Moines.

Family

The Throckmortons have two children. A daughter, Mrs. Tony Lowenberg, is a student at State University of Iowa. Their son, Tom, is a senior at Roosevelt High School in Des Moines. Mrs. Throckmorton is a native of Willows, California.



COARCTATION OF THE AORTA

W. Baird Hudgins, M.D., *Atlanta*

THE POSTOPERATIVE FOLLOWUP of patients operated for coarctation of the aorta is available on a number of patients for ten to 15 years. Recurrence of stenosis operated in late childhood or beyond is very rare. Late aneurysm formation at the site of the anastomosis has not been reported. The blood pressure in the arms usually falls to near normal levels two weeks after surgery and cardiomegaly gradually decreases or disappears. Heavy manual labor and competitive sports have been well tolerated. Operative mortality has been reported in several large series at five per cent or less. Thus, the diagnosis of this congenital anomaly is of extremely important practical interest to the physician and his patient alike.

Coarctation

Coarctation of the aorta is a narrowing of the lumen sufficient to produce a systolic pressure gradient across the obstruction and impede the normal flow of blood. The narrowing is usually situated in the isthmus portion between the left subclavian artery and the insertion of the ductus arteriosus. Single and multiple coarctations have been described from the ascending segment to the abdomen. Edwards has described the different possibilities due to faulty development of the aortic arch. He suggests a practical classification based on anatomic findings and one that is adequate as far as the clinical syndrome is concerned. The basic division is coarctation with closed ductus arteriosus or with patent ductus. When the ductus is patent, the anatomic location of the coarctation proximal or distal to the aortic mouth of the ductus and the presence or absence of systemic collaterals greatly affect the clinical picture. The direction of the shunt through a ductus situated distal to the coarctation is determined by the development of collateral circulation. The collaterals are usually sufficiently developed for an aortic or pulmonary artery shunt to be present. If the ductus has a very large lumen, the fetal circulation can be maintained without the formation of collaterals in utero and the prognosis is much poorer.

Anatomic Appearance

The anatomic appearance of the coarctation is

usually a localized constriction with an hour-glass appearance and poststenotic dilatation. Within the lumen of the constriction, one usually finds a diaphragm with an aperture which further reduces the flow of blood. The most frequently associated defect is a bicuspid aortic valve. Incompetence may develop in this area due to dilatation of the aorta. Bacterial endocarditis frequently occurs as well. Patent ductus is present in nine to 40 per cent of reported series. Sub-aortic stenosis and septal defects are occasionally seen.

The diagnosis is usually based on difference in blood pressure and pulse in the upper and lower extremities. The blood pressure is lower or not obtainable in the legs and the pulses below the defect are weaker and delayed or absent. Palpation of the femoral arteries should always be performed; this will reveal all cases of coarctation except that small minority with a fetal-type circulation. Hypertension is usually present above the defect from the age of ten to 12, but children frequently have near normal pressures. A grade I to II systolic murmur is usually localized to the first and second intercostal spaces to the left of the sternum. Transmission to the back is frequent and is most distinct over the inter-scapular region. Collateral blood flow and complicating anomalies may alter the location, quality, and type of murmur heard. Bounding pulsations in a supra-sternal notch and carotids may be seen.

Ordinary roentgenologic examination usually affords a firm diagnosis without special studies. The deformity of the superior part of the mediastinum, the dilatation of the ascending aorta, the decreased prominence of the aortic knob, the indentation of the descending aorta at the coarcted site with post-stenotic dilatation visible below and enlargement of the left ventricle are usually seen in adults and children as well. Notching of the ribs inferiorly by increasing collateral circulation is usually not seen until late adolescence or adult life.

The majority of adult coarctations reveal left ventricular hypertrophy on the electrocardiogram. In children, this is not the case. Most of the pediatric patients have normal tracings and in the abnormal

group right bundle-branch block has exceeded left ventricular hypertrophy in several series.

Successfully Operated

Many coarctations are operated successfully without special studies. Angiocardiology does provide the exact anatomy of the stenosis, however. The presence of multiple stenoses, elongated coarctations or atresias requiring grafts has prompted many surgeons to utilize this procedure routinely. Cardiac catheterization may establish complicating septal defects, determine pulmonary artery and pulmonary capillary venous pressures in patients with left ven-

tricular failure and finally permit selective angiocardiology in the pulmonary artery.

The repair of coarctation has been performed from infancy to middle age. The ideal elective age for surgery is nine to 13 years. Beyond the age of 40, atherosclerosis becomes a major problem and adds greatly to the surgical risk. With increasing age, the hypertension is less frequently relieved. If the patient is not diagnosed and surgically treated, he may expect hypertension, heart failure, bacterial endocarditis, rupture of the aorta, or a cerebro-vascular accident as a complication or cause of death with a markedly shortened life span.

340 Boulevard, N.E.

Prepared at the Request of the Committee on Professional Education of the Georgia Heart Association.

The doctors of Georgia are neglecting their public relations again. Speeches made to the lay public for the month of June number a mere four. Quite a let down from May. Perhaps there is an excuse this time, and the attendance at the 109th Annual Session of MAG at Jekyll Island can serve as several stars for the state. One must keep in mind, however, that the annual meeting was primarily for the profession; the lay public could not receive the benefit at the time. In the following months, it would bode well if the knowledge gained at the meeting could be imparted to Georgia laymen. They too, deserve to know of decisions made in the House of Delegates, advances in medicine discussed at the scientific sessions, knowledge gained from commercial and scientific exhibits, and ideas and ideals discussed at the GaMPAC breakfast.

In the coming months it is our hope that the State of Georgia will be covered with stars representing knowledge gained by the doctor, and imparted to the laymen, from his attendance at Annual Session.

To share what one has learned is only fair, and by July the message to be told should be apparent on the map.

How well are we telling our story?





PLANS FOR GEORGIA'S NEW MENTAL HEALTH PROGRAM

Addison M. Duval, M.D., *Atlanta*

TODAY PUBLIC MENTAL HEALTH has reached an important and crucial stage of development in Georgia as well as in the entire nation.

A look at recent history of the past ten years corroborates this view. Since World War II, there has been evidence of steady progress with an increasing rate of improvement in the past three years. The peak of interest on the part of the public appears centered around the President's recent special message to the Congress on the subject of mental illness and mental retardation. This very human and stirring message was well received by the Congress and the nation.

Sharing of Costs

For the first time, a President proposes that the Federal Government assist the states in the sharing of costs of direct treatment to mentally ill and mentally retarded citizens. Previously, financial assistance had been largely limited to research and education and to certain demonstration projects. If federal legislation now before the Congress is enacted and this plan approved, it should provide a major stimulus to the states to move forward rapidly in providing improved, broadly based, mental health programs which otherwise would be difficult or even impossible.

The last Congress appropriated funds to be matched by the various states for the purpose of developing long range plans for mental health programs in the several states. The regulations governing the use of these funds have now been completed at the federal level and the Georgia Department of Public Health has submitted an application to the National Institute of Mental Health for our share of these

funds. It is anticipated that this application will be approved and that these funds will be made available to the Department of Public Health about July 1, 1963.

Funds for Development

If granted, these funds may only be used for the purpose of developing plans for Georgia's future mental health program. We expect that these funds will provide approximately \$80,000 per year for a period of two years.

American business and government have provided conclusive proof that long range program plans are necessary for successful results and we believe the same principle applies in the field of mental health and mental retardation.

Ten Year Plan

In Georgia, we propose to develop plans covering the next ten years and from such long range plan, proper priorities can be developed in the hope that these will be approved and financed by the Georgia General Assembly as the program moves forward. We believe it is best to develop our program on this conservative basis but with built-in flexibility providing for adjustments as these are found necessary.

It is my personal hope that we can secure the helpful assistance and cooperation, not only of organized medicine in the State of Georgia, but also from all interested organizations, societies and groups in the State plus that of interested individuals. This kind of comprehensive mental health planning is a most difficult and complex job at best, and every possible source of help will be explored.

A small group of qualified professional people will be employed to carry out the required staff work and these individuals will be assigned to the Division of Mental Health and will work out of our Atlanta office.

Firm Support

It is our firm belief that no adequate mental health program can be developed in Georgia without the firm support of the officers and members of the Medical Association of Georgia. We will hope to work closely with the officers and the council of the Association as we move along in our program plans for the improvement of Georgia's new mental health program.

Dr. Duval

The second of the current series of articles is prepared by Georgia's first Director of Division of Mental Health, Addison M. Duval, M.D. We welcome him to Georgia and to the important position he assumed March 1, 1963. He is well qualified for this task to which the following brief summary of his curriculum vitae will testify:

Prepared at the request of the Subcommittee on Mental Health of the Medical Association of Georgia.

PROGRAM VARIETY SLATED FOR SOUTHERN MEDICAL ASSOCIATION MEETING

Doctors will have quite a variety of scientific programs to select from when the 57th Annual Meeting of the Southern Medical Association is held in New Orleans, Louisiana, November 18-21, 1963. The four day scientific meeting, which annually attracts some 5,000 to 6,000, will feature 48 half-day sessions of 21 medical specialty programs, a symposium on the thermal technics in medicine and a symposium on malignancies, a special two-part program for science writers, eight closed-circuit color television programs, and scientific and technical exhibits.

Edward R. Annis, M.D., President-Elect of the American Medical Association, will be the featured speaker at the President's Luncheon on Tuesday, November 19, it has been announced by Daniel L. Sexton, M.D., St. Louis, Missouri, President of the Southern Medical Association.

Senior medical students from 31 southern medical schools, selected by their classmates, will attend the entire meeting as guests of the Association. This program is designed to permit these young doctors of the future to see a full-scale medical meeting in progress.

Several other medical groups will meet co-jointly with the Southern Medical Association, participating in the programs and activities of the Association as well as their own specialty meetings. Some of these groups are the American College of Chest Physicians, Southern Chapter; College of American Pathologists; The Radiological Society of North America; and the Southern Gynecological and Obstetrical Society. The Asso-

Dr. Duval graduated from the Medical College of Virginia and received his psychiatric training at St. Elizabeths Hospital in Washington, D. C. He remained at St. Elizabeths and served as Assistant Superintendent from 1953 to 1959. From 1959 to 1961 he was Director, Division Mental Disease of Missouri; and for the year prior to coming to Georgia he was Director of Teaching and Research at the State Hospital in Williamsburg, Virginia. He is now Treasurer of the American Psychiatric Association and is a Diplomate of the American Board of Psychiatry.

Dr. Duval is an ex-officio member of the M.A.G. Subcommittee on Mental Health, has met with this committee, and urgently seeks the full support of all physicians, county societies and auxiliaries as well as the members and officers of the Medical Association of Georgia, for an all-out effort to implement adequate and modern mental health services and facilities for our State.

For more information about our state program, call on the Mental Health Subcommittee member who represents your district.

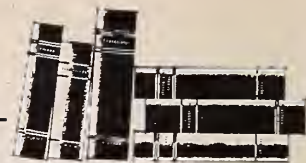
ciation will cooperate with the College of American Pathologists in holding a workshop on professional problems of the pathologist, which will be primarily for senior pathology residents. Radiology Refresher Courses will be co-sponsored by the Association and the Radiological Society of North America.

More than a dozen medical school alumni groups have already made plans to hold alumni reunions during the meeting. Social activities sponsored by the Association include a golf tournament, President's Luncheon, President's Night Dinner-Dance, the Woman's Auxiliary Doctors' Day Luncheon, and numerous activities for the ladies.

Active preparations for the meeting are being carried out by the general officers, Section officers, members of the Association, and members of the Orleans Parish Medical Society. Attendance at this meeting is expected to reach an all-time high.

Officers from Georgia who are assisting in the formulation of the program for the meeting are: Councilor: James H. Byram, M.D., Atlanta. Associate Councilors: Edgar Boling, M.D., Atlanta; Stephen W. Brown, M.D., Augusta; Hugh B. Cason, M.D., Warrenton; Walker L. Curtis, M.D., College Park; and Henry E. Steadman, M.D., Hapeville. Member, Editorial Board: Charles Rieser, M.D., Atlanta. Section Officers: Wood W. Lovell, M.D., Atlanta, Vice-Chairman, Section on Orthopedic and Traumatic Surgery; and Jack C. Hughston, M.D., Columbus, Secretary, Section on Orthopedic and Traumatic Surgery.

PHYSICIAN'S BOOKSHELF



BOOKS RECEIVED

Silver, Henry K., M.D.; Kempe, C. Henry, M.D.; and Bruyn, Henry B., M.D., **HANDBOOK OF PEDIATRICS**, Fifth Edition, Lange Medical Publications, Los Altos, Calif., 1963, 602 pp., \$4.00.

CIBA Foundation Study Group No. 17, **INTESTINAL BIOPSY**, Little, Brown & Co., Boston, Mass., 1963, 120 pp., \$2.95.

CIBA Foundation Symposium, **BILHARZIASIS**, Little, Brown & Co., Boston, Mass., 1963, 433 pp., \$11.50.

Meares, Ainslie, M.D., **THE MANAGEMENT OF THE ANXIOUS PATIENT**, W. B. Saunders Co., Philadelphia, 1963, 493 pp., \$9.00.

Reed, Sheldon C., Ph.D., **COUNSELING IN MEDICAL GENETICS**, Second Edition, W. B. Saunders Co., Philadelphia, 1963, 278 pp., \$5.50.

Noyes, Arthur, P., M.D., and Kolb, Lawrence, C., M.D., **MODERN CLINICAL PSYCHIATRY**, Sixth Edition, W. B. Saunders Co., Philadelphia, 1963, 586 pp., \$8.00.

Bland, John H., M.D., **CLINICAL METABOLISM OF BODY WATER AND ELECTROLYTES**, W. B. Saunders Co., Philadelphia, 1963, 623 p., \$16.50.

Swenson, Orvar, M.D., **PEDIATRIC SURGERY**, Second Edition, Appleton-Century-Crofts, New York, 1963, 779 pp., \$2.00.

ANY SURGICAL TEXT recording the personal experience of a single outstanding surgeon has value in itself. This book certainly bears this out. This text which has had wide popular appeal among those interested in the field of Pediatric Surgery is essentially the same as the preceding edition except for two additional chapters on cardiac surgery. One of Dr. Swenson's contributions in the field of Pediatric Surgery has been to solve the difficult problem of aganglionic megacolon. Two chapters are devoted to this all important subject with detailed photographs of X-ray findings both in infants and older children. In addition, the author has recorded his personal experience, which is considerable, in the congenital and acquired gastrointestinal and thoracic conditions in infants and children. In addition, there are excellent chapters on congenital urinary problems. There are important chapters in the fields of esophageal atresia and tracheoesophageal fistula, and of neoplasms as well as the more commonly encountered hernias. This book serves as a ready reference, since it is a single text, to the pediatrician and surgeon interested in the management of pediatric surgical problems which he encounters. The addition of the chapters on cardiac surgery updates the book and brings to the reader the important anomalies of the cardiovascular system which are now being successfully handled by means of extracorporeal circulation and newer surgical techniques.

G. T. Zwiren, M.D.

McLennan, Charles E., M.D., **SYNOPSIS OF OBSTETRICS**, C. V. Mosby Co., St. Louis, 1962, 464 pp. \$6.75.

THIS IS THE sixth edition of a small book that adequately meets the requirements of a synopsis of an ever

expanding subject. No attempt is made to compare this edition with the previous editions. It suffices to say that the subject matter is condensed in outline in a most palatable and digestive form. The author presents concisely and clearly the basic knowledge of obstetrics acquired through clinical observation and experience during the formative years of the specialty. In addition, adequate attention is given to the more recent advances made in the diagnosis and treatment of major obstetrical complications. Chapters dealing with diseases and injuries of the newborn and medical problems complicating pregnancy add completeness to a well-written book.

This volume should be a welcome addition to the medical student's library and a worthwhile "thumb-nail" reference to the practicing obstetrician.

John M. Miller, M.D.

Stetler, C. Joseph, and Moritz, Alan R., M.D., **DOCTOR AND PATIENT AND THE LAW**, Fourth Edition, The C. V. Mosby Company, Saint Louis, 1962.

THIS IS A REVISED edition of the work of the same name by the late Louis J. Regan, M.D., LL.B., and will undoubtedly replace its predecessor as the standard general text on legal medicine. This edition was prepared by the head of the Legal and Socio-Economic Division of the American Medical Association and accordingly contains the suggested legal forms prepared in recent years by that Division for the use of physicians in dealing with their patients.

The relationship of the physician to the state, hospitals, and medical societies is completely covered and an appendix provides forms for consideration and by-laws for a medical society. The rights and responsibilities of physician to patient are handled on a more selective basis. The volume contains a helpful coverage of the subject of medical testimony which should be of use to practicing lawyers and physicians alike.

The extensive knowledge of the AMA as to the incidence and disposition of malpractice claims combined with an exhaustive review of reported case decisions provide probably the most valuable part of the book to the physician and lawyer. Appendices present important prophylactic suggestions which physicians can ill afford not to peruse today. While the reviewer found the overall approach of this useful volume conservative, he is reminded that he is often also branded conservative when giving legal advice in the field of doctor and patient and the law.

John L. Moore, Jr.

Spencer, H., M.D., **PATHOLOGY OF THE LUNG**, The MacMillan Co., New York, N. Y., 1962, 850 pp., \$7.75.

THIS BOOK CONSISTS of 23 chapters and 850 pages including index. There are 1800 references. It is printed in highly legible type and documented with excellent illustrations. Dr. Spencer has attempted to cover the

entire field of lung pathology with the exception of pulmonary tuberculosis. Correlation between pathology and disordered physiology has been done where possible.

There are interesting chapters on embryology, anatomy, congenital abnormalities, pneumoconioses, radiation effects and many others.

This book is well-written and thorough. It is recommended, particularly to pathologists, and to any physician who diagnoses and treats pulmonary diseases.

John T. Godwin, M.D.

Lennon, G. Gordon, ChM., F.R.C.O.G., M.M.S.A., DIAGNOSIS IN CLINICAL OBSTETRICS, The Williams & Wilkins Co., Baltimore, Maryland, 1962, 291 pp. \$9.00.

THE AUTHOR IS PRECISE, meticulous, and concise in his statements. This makes the understanding of the material easy to comprehend. Generally, he has covered the field of obstetrics quite well. However, he does not mention eye-ground findings in toxemia, or marginal sinus rupture as a cause of bleeding in pregnancy. He might not consider marginal sinus rupture as an entity. The reviewer makes a Papanicolaou smear once a year on all patients, and frequently this includes a pregnant woman on her first office visit. The author has not made mention of these smears.

He has emphasized certain points by repeating them in other chapters, which is good. An example is hazards of post-maturity. The author bitterly opposes rectal examinations during labor and uses the vaginal examinations only.

The book has an unusually large number of good diagrams and pictures to illustrate the text. These are used well and are helpful. The chapter on the urinary tract is outstandingly good.

Robert H. Gillespie, M.D.

Conn, Howard F., M.D., CURRENT THERAPY, 1963, W. B. Saunders Co., Philadelphia, 1963, 775 pp., \$12.50.

THIS BOOK is a collection of wonderfully concise and practical methods of therapy used in treating almost every known disease. The author of each section is a recognized authority on his subject and he casually ex-

plains all the recognized forms of therapy and indicates the one he personally prefers. Most sections give the exact dosage recommendations, which makes the book a practical and quick reference when confronted with an uncommon problem in therapy.

The book is conveniently arranged by dividing the diseases according to specialty or sub-specialty. It does not limit itself to medical treatment methods but points out when surgery is indicated and the type of surgery best suited to the occasion. Quite unexpectedly the book has an excellent section on Obstetrics and Gynecology also.

In my opinion it would be a valuable aid to every general practitioner and to most specialists.

Jeff J. Holloman, M.D.

Shepherd, John T., M.D., PHYSIOLOGY OF THE CIRCULATION IN HUMAN LIMBS IN HEALTH AND DISEASE, W. B. Saunders Co., Philadelphia, 1963, 416 pp., \$12.00.

DURING THE PAST ten years a considerable store of knowledge has been accumulated concerning the physiology of the circulation in human limbs in health and disease. Dr. Shepherd has attempted to correlate this complex data in one book. He has written this book especially for four groups of people: the graduate student with a major interest in the cardiovascular system; the young investigator who is anxious to survey the general field in order to be better prepared to decide upon fruitful areas for study; the experienced investigator looking for a source book of information; the clinician who wishes to have a basic knowledge of the diseases affecting the vascular system.

This book is divided into four sections: 1) a discussion of the nervous control of blood vessels; 2) local control of blood vessels; 3) humoral control of blood vessels; 4) modification of blood vessel activity by disease. All of these sections are filled with many basic facts that lead to a more precise understanding of the vascular problems encountered by the clinician. The section on modification of blood vessel activity by disease is well-organized and easy to read. In general, this book is of the quality one expects from the Mayo Clinic—excellent.

Milton F. Bryant, M.D.

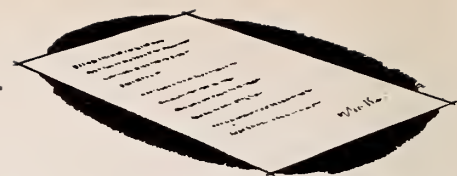
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS NAMES NEW FELLOWS

The American College of Obstetricians and Gynecologists today released the names of 587 new Fellows inducted into the College.

This brings the College's roster to a total of more than 8,000 including Life, Associate, and Junior Fellows. Among them are obstetric and gynecologic specialists from all sections of the United States and Canada.

To become a Fellow of ACOG a physician must have completed an approved program of medical train-

ing, limited his practice completely to obstetrics and gynecology for at least five years, and have the unqualified professional approval of his colleagues. Following are the Georgia doctors recently named to the College: Atlanta, Patrick L. Anders, John R. Bottomy, Charles Wesley Butler, Jr., Earnest M. Curtis, Jr., Byron H. Dunn, Jacob Epstein, Christian R. Moorhead, Mark Pentecost, Jr., David G. Stroup; Cumming, Marcus Mashburn, Jr.; Griffin, Joel Eugene Cox; Macon, Gordon W. Jackson; Savannah, Darnell L. Brawner.



Norris, Jack C., M.D., 490 Peachtree Street, N.E., Atlanta 8, Georgia, "Laboratory Suggestion—A Substitute for Glass Coverslips," *Am. J. Clin. Path.* 39:177 (February) 63.

Glass coverslips are costly items, especially in hospital laboratory use. In order to reduce the expense they entail, the following procedure seems to be helpful, after a bit of experience with it, especially in the preparation and preservation of Papanicolaou ("Pap") smears.

1. The stained "Pap" smear, or other type of preparation, is permitted to dry lightly; or, better still, the excess clearing solution is wiped from the smear, by means of cleansing tissue.

2. A conspicuous drop of Permout (Fisher Scientific Company, So-P-15, No. 12568) is put on the middle part or end of the slide.

3. The slide is next laid flat on the end surface of the work table, and another clean one is held at right angles above the Permout; the gap is then closed, and the drop of Permout is compressed smoothly between them.

4. If the Permout has been evenly distributed, the smear becomes covered with a thin, clear, colorless film; it is then permitted to dry, which occurs relatively quickly.

5. In the finished film, made as directed, the cells may be visualized in almost perfect detail for diagnosis.

Galambos, John T., M.D.; Asada, Makoto, M.D.; and Shanks, James Z., M.D., 69 Butler Street, S.E., Atlanta 3, Georgia, "The Effects of Intravenous Ethanol on Serum Enzymes in Patients with Normal and Diseased Liver," *Gastroenterol* 44:267-274 (March) 63.

After 15 hours of overnight fast, 0.5 ml. per kilogram of ethanol was administered intravenously to 42 patients with active hepatocellular injury and 22 patients without liver disease. One milliliter per kilogram of ethanol was given to an additional eight patients. Glutamic oxalacetic transaminase (GOT), glutamic pyruvic transaminase (GPT), lactic dehydrogenase (LDH) and sorbitol dehydrogenase (SDH) were determined 24, 17, and 0 hours pre, and 0, two, four, eight, and 24 hours post infusion. These were higher in patients with liver disease than in persons without liver injury; also the diurnal variation of the four enzymes was much higher in patients with liver disease than in those with normal liver. However, the intravenously administered ethanol had no significant effect either on the mean enzyme levels or on the variability of the enzyme activities in the serum of groups of patients with or without liver injury. When the effect of ethanol was analyzed for each case and for each enzyme separately, in 26 instances significant differences (at the 5 per cent level) were found in the

postalcoholic serum enzyme activities; of these seven showed an increase and 19 a decrease. If the above four enzyme activities in the serum are capable of reflecting acute hepatocellular injury, then our study failed to demonstrate such injury after the administration of this ethanol load in patients with active liver injury.

Galambos, John T., M.D., and McLaren, John R., 69 Butler Street, S.E., Atlanta 3, Georgia, "Hepatic Uptake Defect in Patients with Gilbert's Disease," *Arch. Int. Med.* 111:214-218 (February) 63.

The demonstration of depressed hepatic uptake of radioactive iodide-labeled iodipamide (R.I.I.) in the presence of normal radioactive iodide-labeled rose bengal (RIRB) uptake appears to be a useful clinical test in the differential diagnosis of some patients with jaundice.

Daoud, Georges, M.D.; Kaplan, Samuel, M.D.; Perrin, Eugene V., M.D.; Dorst, John P., M.D., Cincinnati, Ohio; and Edwards, Kathryn, M.D., Department of Pediatrics, Emory University, Atlanta 22, Georgia, "Congenital Mitral Stenosis," *Circulation* 27:185-196 (February) 63.

Seven cases of congenital mitral stenosis are described. An associated coarctation of the aorta was present in one case. Clinically, these cases showed repeated pulmonary infection, pulmonary edema and congestive failure. All cases showed left atrial enlargement by X-ray, and all had apical diastolic murmurs. The first heart sound was loud in the majority of cases and the murmur frequently had pre-systolic accentuation. Right ventricular hypertrophy was present by physical examination and electrocardiogram in most cases. An opening snap was heard in one case. P waves of the electrocardiogram were frequently large and notched.

The mitral valves were formed with a funnel shape and fused commissures. The chordae tendineae were thickened, shortened and atrophic in varying degrees of severity. Endocardial fibrosis was found frequently to involve the left atrium and mitral valve.

The differential diagnosis would include those congenital and acquired cardiac lesions which present as left atrial blockade.

The medical and surgical results were generally poor in those cases which presented with difficulty in infancy and early childhood. If surgery is undertaken it is best done with cardio-pulmonary by-pass in order for the surgeon to visualize the valve deformity.

Ingram, Robert C., D.D.S.; Krantz, Simon, M.D.; Mendeloff, M.D.; and Leslie, Harriet, B.A., 4158 Peachtree Road, N.E., Atlanta 19,

Georgia, "Exfoliative Cytology and the Early Diagnosis of Oral Cancer," *Cancer* 16:160-165 (February) 63.

Despite the accessibility of the oral cavity to examination, it is discouraging to be confronted with the degree of advanced neoplastic disease that one sees in a tumor clinic.

A study was made to evaluate the potentiality of exfoliative cytology as a procedure for early diagnosis of oral cancer. To this end, careful examination of oral cavity was performed by members of the dental and tumor services and any suspicious lesion studied by exfoliative cytology and biopsy.

The institution of this study resulted in detection of ten small carcinomas in 422 lesions observed in mouth. In eight, the cytology examination was basically responsible for early detection. All lesions were early and showed none of the so-called typical signs of malignancy.

Cytological examination is capable of detecting small oral carcinoma. The specimen is easier to collect than biopsy. We do not believe, however, that it is as accurate as biopsy.

Grady, Edgar D., M.D.; Sale, Walter T., M.D.; and Rollins, Luther C., M.D., 1938 Peachtree Road, Atlanta 9, Georgia, "Localization of Radioactivity by Intravascular Injection of Large Radioactive Particles," *Ann. Surg.* 157: 97-114 (January) 63.

Particles of yttrium oxide were exactly sized so that when a suspension of them was injected into an artery, the particles would be trapped in the circulation and could not pass on to the venous circulation. The material was then exposed to neutron bombardment so that Yttrium-90 radioisotopes were made.

When such a suspension of radioactive particles was injected intra-arterially in rabbits and dogs, the following conclusions were drawn:

The distribution was always homogeneous.

40 to 70 per cent of the particles were trapped in the kidney or thigh muscles when the renal or femoral artery was injected.

No harm was done by the injections, when up to 8 mc/kg were used.

Intravenous injections led to trapping of 70 per cent uniformly through both lungs.

If the portal vein was injected, 100 per cent of the radioactive particles were homogeneously spread throughout the liver with no harm to the liver.

Twelve patients with advanced cancer were treated and results showed good palliation in lung and pelvic cancer. There were no significant complications. Inoperable disease has been controlled in lung and pelvic areas for periods up to eighteen months.

Note: Since the publication, 19 additional patients have been treated. These include lung, liver, pelvic and brain cases. Localization of radiation appears excellent. Complications continue to be relatively insignificant. Excellent results are being obtained in about one out of four otherwise hopeless cases.

Wolcott, M. W., M.D.; Shover, W. A., M.D., Coral Gables, Florida; and Jennings, W. D., M.D., V.A. Hospital, Atlanta, Georgia, "Spontaneous Pneumothorax — Management by Tube Thoracostomy and Suction," *Dis. Chest* 43:78-81 (January) 63.

"Sixty-five cases of spontaneous pneumothorax have been observed over the past seven years and management in the majority of the cases was with tube thoracostomy. Open thoracostomy was necessary in only six cases. Conservative management for each had good results with minimum mortality and no morbidity.

Method of Management: Management consisted of closed tube thoracostomy with immediate mild suction. A No. 18-22 French rubber catheter was introduced into the chest in the ninth or tenth interspace in the posterior axillary line. Introduction was through a trocar under local anesthesia at the bedside. Suction of 4-10 cm of water was applied immediately to the catheter using a Stedman pump connected to an underwater seal bottle. A second tube was placed in the second anterior interspace and connected through a "Y" connector to the suction bottle when expansion was not completed in 12-24 hours. By this method, the lung could be reexpanded promptly in the majority of patients. A mild pleuritis occurs as a result of the presence of air within the chest cavity. Prompt reexpansion of the lung takes advantage of this mild inflammatory reaction and allows adherence of the lung to the parietal pleura. Any pleural fluid drains through the tube placed as it is in the ninth or tenth interspace."

Witherington, Roy, M.D., Medical College of Georgia, Augusta, Georgia, "Experimental Study on Role of Intravesical Ureter in Vesicoureteral Regurgitation," *J. Urol.* 80:176-179 (February) 63.

Destruction of sufficient intravesical ureter will alone, without alteration of any other factor at the ureterovesical junction, allow vesicoureteral regurgitation to regularly occur. Under this circumstance the "flutter valve" action of

the intravesical ureter is lost and vesicoureteral regurgitation occurs. The gross anatomical defect under this circumstance is discernible as a patulous ureteral orifice.

Reconstruction of an adequate length of intravesical ureter should correct vesicoureteral regurgitation in an animal or human with a gaping ureteral orifice secondary to loss of intravesical ureter. The frequency with which vesicoureteral regurgitation is eliminated by ureteral ostioplasty is in direct proportion to the length of the reconstructed intravesical ureteral segment.

The variations in technique that might be utilized in ureteral ostioplasty are many. Bischoff's technique is simple and utilizes the principle of circumferential proliferation of a buried strip of epithelium. The author's original technique is likewise simple and has been used clinically with success.

Ureteral ostioplasty offers the following advantages over ureteral re-implantation as the primary surgical procedure at the ureterovesical junction designed to eradicate vesicoureteral regurgitation: 1) Simplicity. 2) Continuity of the urinary tract, including its blood supply, is maintained. 3) Postoperative obstruction at the site of ostioplasty is unlikely. 4) If ostioplasty fails the operation can be repeated or ureteral reimplantation can be performed. If ureteral re-implantation is performed as an initial procedure and it fails, it is difficult to perform further surgical procedures upon the ureterovesical junction. 5) The cure rate appears to be acceptable.

Thresh, Agotho, M.D., Department of Pathology, Emory University School of Medicine, 36 Butler Street, S.E., Atlanta 3, Georgia, "Vascular Malformations of the Cerebellum," *Arch. Path.* 75:65-69 (January) 63.

Intracranial congenital vascular malformations are uncommon (0.5% to 1% of all intracranial tumors) and are especially rare in the cerebellum (probably less than 10% of intracranial vascular malformations). These lesions were found in four patients coming to autopsy in the Emory University Department of Pathology during an 18-month period. Hemorrhage from the lesion was the cause of sudden and unexpected death in two patients. One of these was a woman in her sixth month of pregnancy who had no associated complicating conditions. A third patient presented premonitory symptoms of headache, ataxia, and lethargy. The fourth was a premature infant.

Stone, H. Harlon, M.D., and Dominy, Dole E., M.D., 69 Butler Street, S.E., Atlanta 3, Georgia, "Transtacheal Injection as an Adjunct to Bronchoscopy," *Am. Surgeon* 29:142-144 (February) 63.

Percutaneous transtracheal injection of a detergent and saline mixture was performed 446 times in 201 patients. The major indication was an ineffective cough with retained bronchial secretions.

A satisfactory result was obtained in 93 per cent, as evidenced by establishment of a productive cough and clinical resolution of the acute pulmonary process. The procedure should not replace therapeutic bronchoscopy, but it is a useful adjunct to prevent the necessity or to reduce the frequency of bronchoscopy, when used early in post-operative and post-traumatic states.

Thoroughman, J. C., M.D., 4158 Peachtree Road, N.E., Atlanta 19, Georgia, "Surgery and the Patient with Intractable Peptic Ulcer," *Am. J. Surg.* 105:334-337 (March) 63.

Peptic ulcer surgery performed for the indications of hemorrhage, obstruction, or repeated perforation is rewarded by a high percentage of good results. Using the same operation, there is an appreciably lower percentage of good results when the indication for surgery is intractability. Age, increased complication rate, longer average duration or symptoms, and a disproportionately longer hospital stay set apart this group of ulcer patients. They warrant more intensive study than has yet been made, especially since surgery for intractability is elective.

The records of 80 such patients were reviewed.

Previous complications, the ulcer pathology, back pain, service connection, and associated disease appear to play no significant part in determining good or poor results after surgery. On the other hand, the response of the patient to his disease as manifested by his cooperation with the physician, his work record, motivation, the modification or elimination or psychological and social factors precipitating or aggravating his ulcer, his adjustment to his environment show a greater correlation with the results after surgery. Rating of the specific environmental factors giving support to the patient serves as an adjunct to clinical criteria commonly used in predicting good or poor results in the intractable ulcer patient.

MAG REPORTS ON BLOOD BANKS AND TRANSFUSIONS

Doctors Mervin Ellstadt, Shadle and Jennings, in California, have suggested that banked blood, which was formerly unsuitable for OPEN HEART SURGERY, can be utilized in emergency heart operations by adding first Heparin and then Calcium Chloride, with sodium bicarbonate to neutralize the citrated blood whenever it is to be given to children. Further infor-

mation may be obtained about the method by writing to Dr. Mervin Ellstadt, Memorial Hospital, Long Beach, California. In ten instances there were only two fatalities. We feel that this process should prove to be a valuable procedure, very likely life saving, especially so when fresh blood is unavailable in emergency surgery.

Jack C. Norris, M.D., Chairman Sub-Committee on Blood Banks

THE ASSOCIATION



DEATHS

LUTHER H. KELLEY, 76-year-old Atlanta obstetrician, died at his home April 13, 1963.

He was graduated from Emory School of Medicine in 1914, and had practiced in Atlanta since then. He was a veteran of World War I.

Dr. Kelley was a member of Virginia Avenue Baptist Church, East Lake Country Club, Atlanta Athletic Club, and was an honorary member of the Fulton County Medical Society. He was a Shriner.

Surviving are his widow; sisters, Mrs. Gladys Whiting of Toccoa, and Mrs. C. Bain, and Mrs. Max Mize of Royston; brothers, Tom Kelley and Rev. E. D. Kelley of Toccoa, and several nieces and nephews.

DAVID PEARCE BELCHER, 82, of Pelham died April 13, 1963, at Howard Hospital in Pelham.

Dr. Belcher was a member of Hand Memorial Church, American Legion Post No. 144, Pelham Masonic Lodge No. 312 F & AM, Shriner. He served in the Medical Corps during World War I. While in service he was awarded the Silver Star and the French Medal of Honor, the Croix De Guerre. He was graduated from Atlanta Medical College in 1909. After graduation he practiced in both Grady and Mitchell Counties.

He is survived by his wife, Mrs. Opal Belcher, Pelham; four sons, Pierce Belcher, Madison; Fred Belcher, Nashville, Ga.; Frank Belcher, Pelham; and William A. Belcher, Lilburn; 10 grandchildren and one great-grandchild.

SOCIETIES

CARROLL - DOUGLAS - HARALSON MEDICAL SOCIETY met April 1, at Villa Rica. Carrollton attorney, Henry Head, presented a program on certain medical-legal aspects with particular emphasis on the doctor as a witness.

The Annual Southwest Georgia Medical Seminar, under sponsorship of the DOUGHERTY COUNTY MEDICAL SOCIETY in cooperation with the American Academy of General Practice, was held at the New Albany Hotel, Albany, April 25. Featured on the program were Robert P. Morehead, M.D.; Lawrence B. Leinbach, M.D.; and Thomas F. O'Brien, M.D. all of the Bowman Gray School of Medicine, Wake Forest College, Winston-Salem, N. C., and Edgar Woody, Jr., M.D., Atlanta, Editor of the *Journal of the Medical Association of Georgia*. Also participating in the program were W. Frank McKemie, M.D., Albany, and Richard T. Myers, M.D.

FIRST DISTRICT MEDICAL SOCIETY has recently elected new officers for 1963 at the meeting held

in Statesboro. Elected as President was L. H. Griffin, Claxton; David Robinson, Savannah, President-elect; John D. Deal, Portal and Statesboro, Vice-president; Vincent J. Cirincione, Savannah, Secretary; and L. Frank Lovett, Statesboro, Treasurer.

A special meeting of the GEORGIA MEDICAL SOCIETY was held April 22, in Savannah, to discuss the report of the Metropolitan Health and Hospital Council.

Members of the SEVENTH DISTRICT MEDICAL SOCIETY were guests of the FLOYD COUNTY MEDICAL SOCIETY April 3, in Rome. Doctors presenting papers on the program were Carl R. Hartrampf, Atlanta, "The Management of Hand Injuries;" William P. Thompson, Atlanta, "Problems Encountered in the Interpretation of Laboratory Data;" W. Phillip Warner, Jr., "Helpful Measures in Treatment of Low Back Pain;" and Sidney Olansky, Atlanta, "Cutaneous Manifestations of Disease."

PERSONALS

First District

HOWARD J. MORRISON, Savannah, has recently been named Committee Chairman for a Georgia Medical Society program for administering oral polio vaccine to residents of the Chatham County area.

Second District

No news submitted.

Third District

A former medical missionary in the Belgian Congo, JOE WEBBER of Columbus, spoke to the Woman's Auxiliary to the Muscogee County Medical Society at their meeting April 17, in Columbus. Dr. Webber spoke on his views of the doctor and his wife in the medical missionary capacity.

LEONARD T. MAHOLICK, Director of the Bradley Center, Columbus, recently returned from Chicago where he addressed the assemblage of physicians attending the Fifteenth Annual Meeting of the American Academy of General Practice. His topic was "The Doctor and the Discharged Mental Patient."

Speaking on the television show, "Dateline Jaycee," Columbus, on April 6, was WILLIS P. JORDAN, Columbus. Dr. Jordan spoke against President Kennedy's proposed hospital insurance program.

Fourth District

Attending the recent Fifteenth Annual Meeting of the American Academy of General Practice held in Chicago was T. A. SAPPINGTON, Thomaston.

Fifth District

JOHN T. GALAMBOS, Atlanta, presented a paper on "Diagnostic Test for Gilbert's Disease" before the American College of Physicians in Denver, Colorado, April 4.

JAMES B. MINOR, Atlanta, Cardiologist to the Open Heart Surgical Team of St. Joseph's Hospital, presented a program at the April meeting of the Medical Staff of Memorial Hospital of Washington County.

Atlanta psychiatrist, WINSTON E. BURDINE, addressed the Southeastern Hospital Conference for Dietitians, May 3 in Atlanta. Dr. Burdine's topic concerned food and its relationship and effect on emotions.

Five Atlanta physicians have recently been named to the Board of Trustees of the Northside Hospital Association. They are, LEGH R. SCOTT, JR.; JOHN M. MCCOY; CHARLES M. SILVERSTEIN; LEA RICHMOND; and JOSEPH A. WILBER.

CHENY C. SIGMAN, JR., Atlanta, has recently been appointed Allergy Editor for the new journal, *Pediatrics Digest*.

Testimonial in recognition of his outstanding work and service in the community was given JOSEPH YAMPOLSKY, Atlanta, at the Annual Physicians' and Dentists' dinner in behalf of the Atlanta Jewish Welfare Fund held April 7, at the Mayfair Club, Atlanta.

Sixth District

No news submitted.

EXECUTIVE COMMITTEE OF COUNCIL MEETING

THE REGULAR MONTHLY meeting of the Executive Committee of Council was called to order at 8:10 P.M. April 15, 1963, at the MAG Headquarters Building, Atlanta, Georgia, by the Chairman, President Thomas W. Goodwin.

The members attending were: Thomas W. Goodwin, Augusta; John T. Mauldin, Atlanta; George H. Alexander, Forsyth; J. G. McDaniel, Atlanta; Lee H. Battle, Rome; John S. Atwater, Atlanta; and Fred H. Simonton, Chickamauga. The staff members present were: Mr. Milton D. Krueger, Mr. James M. Moffett, and Mrs. Catherine Wooten.

Reading of Minutes

Mr. Krueger reviewed the minutes of the March 23, 1963, meeting of the Executive Committee, and the minutes were approved as read.

Treasurer's Report

Dr. Atwater gave the Treasurer's Report. He stated that the Contingent Fund was low and if further expenditures were made from it there would have to be additional funds transferred to the Contingent Fund. It was suggested that if money was needed the Contingent Fund could be supplemented by transferring money from the savings account. The treasurer's report was approved as read.

MAG Attorney's Statement for Services

Secretary Mauldin presented the MAG Attorney's statement for services rendered in the case of Bell v. the Medical Association of Georgia, that was dismissed. It was suggested that this be presented at the May Council meeting.

Seventh District

W. D. HALL, Calhoun, recently made a contribution to the Gordon County Hospital in memory of the late ZEB V. JOHNSTON, to furnish a private room in the new wing of the hospital.

Five Rome Doctors, ED BOSWORTH, RICHARD CONNELL, RUSSELL RAGSDALE, JAMES KELLEY, and JOHN FOWLER recently participated in a "Teen Topic" discussion on questions of health in a program sponsored by the Floyd County 4-H Council, April 8.

Eighth District

On April 27, VILDA SHUMAN, Waycross, was honored at the annual Alumnae Day of the Woman's College of Georgia. She received the 1963 Alumnae Achievement Award in recognition of her work in the field of pediatrics and medicine.

J. W. WALKER, Nahunta, recently spoke to the Hoboken High School and the Lion's Club of Nahunta.

Ninth District

GRADY N. COKER, Canton, recently announced the opening of the Coker Medical Care Nursing Home. Included on the nursing home staff, in addition to Dr. Coker, will be CHARLES ANDREWS, ARTHUR HENDRIX, and R. T. JONES, III, all of Canton.

Cornelia physician, WILLIAM ARIAIL, has recently announced plans for a new combination office and clinic building to be built in the City Hall district of the city.

Tenth District

No news submitted.

Ad Valorem Tax Case Status

Dr. Mauldin reported on the status of the ad valorem tax case. The MAG Attorney had forwarded copies of the pleadings of the Taxing Authorities to the MAG petition, raising the issue of the validity of the ad valorem taxes assessed against the real property of the Medical Association of Georgia. The results of the argument should come up within three months and the Attorney will so inform MAG.

Appointment to State Hospital Advisory Council

Dr. Mauldin stated that Dr. Rafe Banks' term of office will expire July 1, 1963, on the State Hospital Advisory Council which advises the State Board of Health on matters pertaining to Hill-Burton Construction, Hospital and Nursing Home Licensure and State Hospital Indigent Care Programs, and asked for an appointment to this position. On motion (Mauldin-Atwater) it was voted to reappoint Dr. Banks for another term of four years.

Appointment to MAG Mental Health Subcommittee

Mr. Krueger stated that an appointee had declined to serve on this committee. On motion duly made and seconded it was voted to ask Dr. Goodwin to appoint a replacement from the Second District.

Joint Committee on Radiology

Dr. Mauldin discussed the problem of radiologists' contracts with hospitals, and asked the Executive Committee's opinion as to the best plan of investigation. It was suggested that the Georgia Hospital-Medical Council should study the problem. On motion (McDaniel-Alexander) it was voted and approved to ask the Georgia Hospital-Medical Council to investigate this problem.

THE ASSOCIATION / Continued

Resolution on Podiatry

Dr. Mauldin read the Resolution submitted at the March Council meeting, with the suggested changes by the MAG Attorney. After discussion the Resolution was changed further as follows:

It was suggested that the AMA be asked to give MAG data on the required education for podiatrists before the Annual Session and to submit the Resolution as amended to Council at the May meeting for submission to the House of Delegates as a Supplemental Report of Council.

Mr. Moffett stated that the Fulton County Medical Society had submitted a Resolution on Podiatry. After reading this Resolution to the Executive Committee on motion duly made and seconded, it was voted to recommend to Council that the Resolution submitted above not be introduced in view of the fact that the Fulton County Medical Society had submitted a Resolution on Podiatry that will cover the salient points in this Resolution.

Georgia Podiatry Association Request

Dr. Mauldin read a letter from Dr. Dalton McGlamry, Secretary-Treasurer of the Georgia Podiatry Association, asking for negotiation between podiatry and medicine regarding inclusion of podiatry in Blue Shield. It was stated by members of the Executive Committee that MAG has no authority to negotiate with Blue Shield on the inclusion of podiatry. On motion (Mauldin-McDaniel) it was voted that Dr. McGlamry should be informed that this matter will be presented at the May Council meeting.

Headquarters Office Report

Mr. Krueger reported that he and Mr. Moffett had been received well on the visitation program for "Operation Home-town."

(1) Letters to designated recipients of Certificates of Appreciation at 1963 Annual Session were approved.

(2) Letter from Dr. Blasingame of AMA, regarding possibility of further discussion regarding the National Blue Shield Senior Citizens Plan was read. It was voted that Dr. Blasingame should be informed that MAG is satisfied with the 1962 decision as reported to Mr. Stetler.

New Business

(1) AMA Committee on Osteopathy and Medicine Breakfast Meeting: Mr. Krueger read a letter about sending representatives from MAG to this breakfast meeting on June 19, 1963, at the Traymore Hotel, in Atlantic City. On motion duly made and seconded, it was voted to ask the Chairman of the AMA Delegates delegation to designate someone to attend and to write the AMA that MAG would have representation at the meeting.

(2) Joint Council on Paramedical Education Meeting: Dr. Mauldin read a request for a representative from MAG to attend a meeting of the Executive Committee of the Joint Council on Paramedical Education to be held in Atlanta on April 23, 1963. On motion duly made and seconded it was voted to ask Dr. R. B. Hornsberger, Atlanta, pathologist, to attend this meeting.

(3) State Board of Medical Examiners Hearing, April 17, 1963: Dr. Goodwin asked for representation at a hearing scheduled for April 17 in compliance with a previous liaison request to the Medical Examining Board by MAG. Dr. Savage had contacted Dr. Goodwin about this hearing and asked that an MAG representative attend. Dr. McDaniel, Dr. Walker and Dr. Bishop were suggested to represent MAG, and Mr. Krueger was asked to attend.

(4) Certificate of Service: At the March Council meeting, Dr. Mercer had suggested that Executive Committee consider the possibility of awarding Certificates of Service for members who are elected to certain positions. As this meeting's agenda is to be kept to a minimum, this item was suggested for the June Executive Committee meeting. The Executive Committee approved this suggestion.

(5) Drs. Simonton and Goodwin discussed the possible expansion of services at the Talmadge Memorial Hospital.

CLINICAL CENTER STUDY OF CHRONIC MYELOGENOUS LEUKEMIA

The cooperation of physicians is requested in a study of chronic myelogenous leukemia being conducted by the Chemotherapy Service of the National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Referrals of patients with chronic myelogenous leukemia are needed. Particularly needed are those in the 20 to 40 year age group with high white blood cell counts and platelet counts, for studies of newer chemotherapeutic agents and as a source of white cells and platelets for *in vitro* and *in vivo* study.

Physicians who wish to have their patients considered for the study may write or telephone:

Dr. Paul P. Carbone
Chemotherapy Service
Medicine Branch
National Cancer Institute
Bethesda 14, Maryland
Telephone: 496-4251

AYERST OFFERS FILMS FROM MEDICAL LIBRARY

As a service to the medical profession, Ayerst Laboratories is pleased to offer films from its Medical Film Library for showing without charge to interested professional audiences.

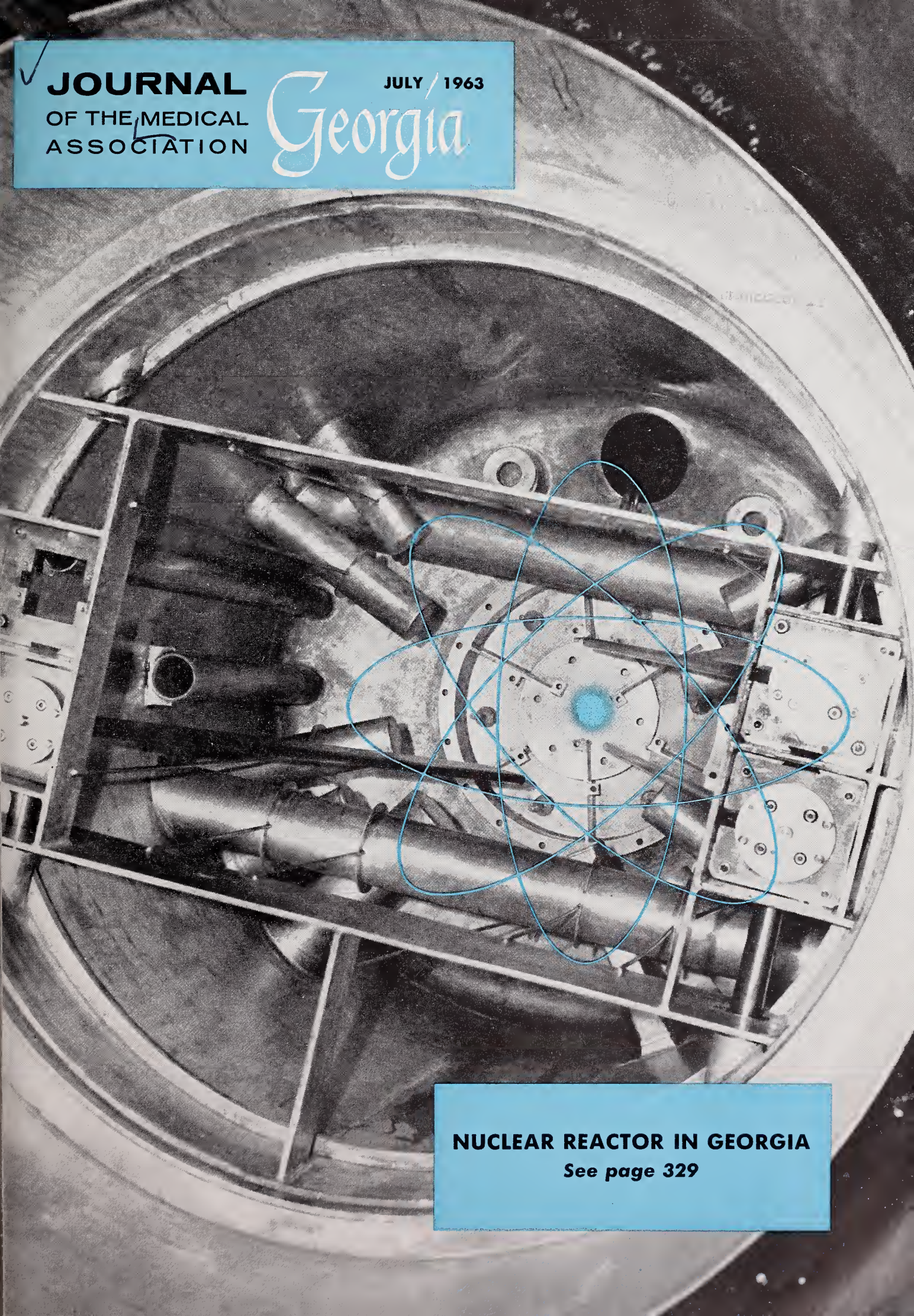
A catalog describes the 39 films currently available. They deal with a variety of medical subjects, including estrogen therapy, epilepsy, anesthesiology, gastroenterology, otology, rhinology, proctology and numerous others. Most of these films are in color and all are 16 millimeter sound. Each film has been written, directed and produced with the greatest technical and professional care. Black and white films are kinescopes of closed circuit television programs. These films may be of interest to members and appropriate for showing at film program meetings.

Films are available on loan by simply completing an order form and mailing it to the regional office of the film distributor, Ideal Pictures. Please allow at least three weeks for delivery and submit alternate selections or dates. A film-request form will accompany each film sent out on loan. Additional order forms may be obtained through an Ayerst representative or from Ideal Pictures.

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NUCLEAR REACTOR IN GEORGIA

See page 329

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Contents

Scientific Articles

- PEPTIC ULCER: LOW AILMENT ON THE TOTEM POLE?
Charles W. Hock, M.D. 311

- EXPERIENCES WITH MAMMOGRAPHY AT
EMORY UNIVERSITY HOSPITAL
James V. Rogers, Jr, M.D., and R. Waldo Powell, M.D. 317

- SIMPLIFIED APPROACH TO OTITIS EXTERNA
Ben H. Jenkins, M.D. 319

- HYPOTHERMIA IN GENERAL SURGERY
B. A. Addison, M.D., and E. R. Jennings, M.D. 322

Special Article

- SOCIALIZED MEDICINE
James W. Harkess, M.D. 325

Editorials

- THE FRANK H. NEELY NUCLEAR RESEARCH CENTER . . . 329
OPERATION HOMETOWN 330
GEORGIA SCHOOL FOR THE DEAF 331
FREEDOM WITH RESPONSIBILITY 332

Features

- How Well Are We Telling
Our Story? 342
President's Letter 333
Cancer Page 335
Heart Page 337
Legal Page 339
Mental Health Page 341
Physician's Bookshelf 343
Current Clinical Concepts . . . 345

The Association

- Deaths 346
Societies 346
Personals 346
MAG Council Meeting,
May 4 347
MAG 1963-64 Organizational
Meeting of the Council,
May 8 348
Advertising Index 48A

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The Georgia Tech research reactor containment vessel. Photograph compliments of the Georgia Tech photo lab, Atlanta.

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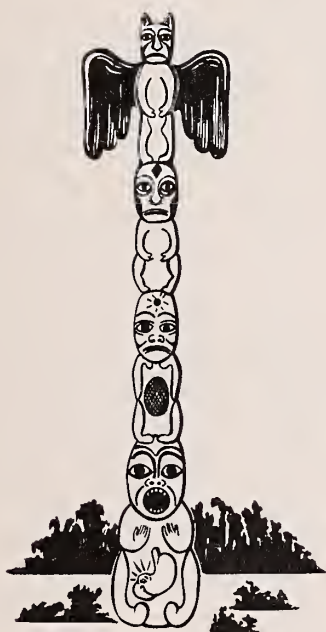
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PEPTIC ULCER: LOW AILMENT ON THE TOTEM POLE?

Charles W. Hock, M.D., *Augusta*



Effective therapy must be designed to provide treatment for the "whole" patient.

OVER THE PAST two and one-half decades, peptic ulcer seems to have made a steady descent on the pathological status scale until now it has evidently reached a point only slightly above that reserved for the more innocuous ills of man. At least such a loss of status offers a reasonable explanation for the all too apparent trend away from adequate diagnostic investigation in suspected peptic ulcer, and for the failure to appreciate the dangers inherent in incomplete diagnostic and therapeutic effort.

Twenty-five Years Ago

Twenty-five years ago the patient with suspected peptic ulcer was an almost certain candidate for a barrage of diagnostic procedures. With the establishment of a positive diagnosis, the patient was placed on a strict therapeutic regimen that usually included the Sippy diet — or some variation thereof, and usually excluded such irritating but pleasurable commodities as tobacco and liquor. The lot of the ulcer

patient in those days was a rigorous one, but at least he knew definitely that he did have an ulcer and he had the assurance of an optimal therapeutic program. Should the ulcer patient of today be expected to settle for less?

In the 16 years in which I have limited my practice to gastroenterology, my consultation room has held an astonishing number of patients in whom the previous diagnostic effort has been inadequate and the therapeutic effort faulty. Many of these patients, it should be noted, were referred to me by their own physicians. When one considers that the consultation rooms of my confreres have, for the most part, held like numbers of like patients — many of whom undoubtedly also were referred by other physicians, it would seem in order to suggest that a reappraisal of current methods of handling peptic ulcer is needed.

Among the diagnostic methods commonly reported by these patients is one which may be called

the "Antacid, p. c." test. In such a case, the patient has come to his physician complaining, usually, of epigastric distress. After a cursory examination to rule out an acute abdomen, the physician instructs his patient in the "Antacid, p. c." test. The instructions are simple and easy to follow: purchase a bottle of an aluminum hydroxide preparation and take one teaspoonful after every meal. *If the aluminum hydroxide relieves the distress, the patient has a peptic ulcer.*

Since most individuals are fairly susceptible to suggestion, the chances are that, for a short time at least, the aluminum hydroxide will relieve the distress whether or not the patient actually has peptic ulcer. If a subsequent, complete diagnostic work-up fails to produce any demonstrable evidence of ulceration in the gastrointestinal tract — or any other pathology, he is in danger of nothing more serious than a little psychic trauma, sustained when he received the erroneous diagnosis of peptic ulcer. However, for the patient with a missed diagnosis for carcinoma of the stomach, for example, the results may be tragic.

Missed Malignancy

Missed malignancy is also a distinct possibility when radiologic examination is made, and the results interpreted, by non-experts. All too often today, radiologic study is carried out by persons without either enough training or enough experience to interpret X-ray and fluoroscopy findings. Radiologic examination is useless *unless it is in the hands of a qualified and experienced radiologist*. It is equally important for the other diagnostic tests and laboratory findings to be interpreted by thoroughly trained, thoroughly experienced individuals who have also developed the acuity necessary for the diagnosis of gastrointestinal-tract lesions.

The Casual Approach to Therapy

The mainstay of ulcer management for the advocates of the casual school of therapy appears to be a soft diet and an anticholinergic, the latter to be taken either t.i.d., p. c. or b.i.d. In some cases, perhaps, such therapy would suffice, assuming that the patient understands fully which foods make up a soft diet. Unfortunately, the average person thinks that a soft diet means a diet of foods of soft consistency. Therefore, in the absence of careful diet instructions —and written instructions are mandatory—the less discerning pa-



tient may well be treating his ulcer with chili con carne, barbecue hash cat-fish stew, bourbon and all manner of other highly irritating substances which fall into the "soft consistency" category. Still others of these ulcer

patients subjected to the casual school of therapy may have the impression that anticholinergic constitutes the total treatment program. Moreover, they may proceed to wash the tablet down with beer, wine or whiskey.

A Full Diagnostic Effort

While the importance of a carefully planned therapeutic regimen cannot be overemphasized, establishing the correct diagnosis remains the first requirement. Before outlining the elements of a full diagnostic effort, it may be useful to review a few of the facts — well-known but sometimes forgotten or overlooked.

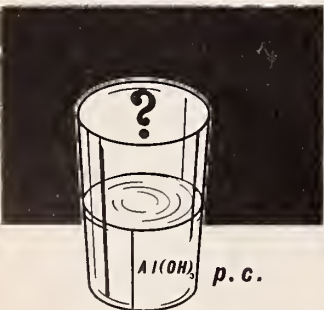
By definition, peptic ulcer is a sharply circumscribed loss of tissue resulting from the digestive action of acid gastric juice. The world-wide incidence is estimated at ten per cent. Peptic ulcer occurs more often in males than in females, this ratio being 4:1.¹ For convenience, the balance of the pertinent data is presented in table form (Tables I. and II.).

TABLE II. PAIN PATTERN FOR PEPTIC ULCER

Absent	Present
Before breakfast	1 to 4 hours after breakfast
During and immediately after lunch	1 to 4 hours after lunch*
During and immediately after dinner	1 to 4 hours after dinner† plus Midnight to 2 A.M.

* Usually more severe in the afternoon than in forenoon.
† Usually less severe in the evening than in afternoon.

Although the tendency to regard the patient with peptic ulcer as a "Case" rather than an individual is more common among medical students, a surprising number of physicians share this attitude. An additional number of physicians fail to consider the peptic ulcer patient in his entirety, so to speak, or as a "whole" patient. The success of an ulcer management program is often tied to utilizing this concept of the "whole" patient by formulating a therapeutic plan which takes into account, in addition to the physical organism, every aspect of the patient's life. The proper point at which to start considering the "whole" patient is early in the diagnostic effort and, therefore, section A of the diagnostic program outlined below contains all of those factors which deserve consideration.



Diagnostic Program

A. Detailed and careful attention should be given to:

1. presenting complaint(s)
2. general medical history
3. family history
4. emotional make-up
5. mental capacity
6. education
7. previous and present working conditions
8. present home environment
9. recreational habits

B. A complete physical examination.

C. Laboratory Work-up:

1. free hydrochloric acid determinations: by Ewald or alcohol test meal, or by histamine test meal; if free HCL is absent, confirm by Diagnex Blue test.
2. stool examination for:
 - a. pathogens
 - b. blood
3. urinalysis
4. Kahn test
5. complete blood count

The above suggested laboratory tests represent the ideal and are highly desirable if there is no deterrent to their use. However, when for economic or other reasons such extensive laboratory testing is impracticable, one may concentrate all effort in the lab on free hydrochloric acid, *because chronic peptic ulcer does not occur in the continued absence of acid gastric juice.*

D. Radiologic examination for demonstration of:

1. ulcer crater
2. deformity produced by crater
3. both

The ulcer crater — the only definite radiologic evidence of active ulcer — is demonstrated in at least 90 per cent of patients with active gastric ulcer, and in 50 per cent to 70 per cent of those with active

duodenal ulcer. It is important to remember that — except for the hour-glass contracture one very occasionally sees — the contour of the stomach is rarely altered by the healing of a gastric ulcer. On the other hand, a healed duodenal ulcer may cause some contracture which results in a deformity of one or both curvatures of the duodenal bulb.

E. Gastroscopic examination for visualization of:

1. those small lesions which are not demonstrable by radiologic means

An Optimal Therapeutic Regimen

For the peptic ulcer patient who presents no signs or symptoms of complications, hospitalization is usually not only unnecessary but also may impose an unwelcome financial burden or interfere seriously with work, business or the household. In either case the worry generated would tend to cancel out any advantages hospitalization might offer. There are three major exceptions to this rule, however: 1) a living situation incompatible with observance of an ulcer management program; 2) a family situation characterized by stress and tension; and 3) the presence of apparently intractable symptoms.

Ulcer management consists of four components: diet, antacids, anticholinergics, and tranquilizers and/or sedatives. In connection with the diet, two basic rules could be universally observed with profit to patient and physician. First, always give the patient *written* dietary instructions; and second, unless the patient is markedly underweight, prescribe plain milk instead of the customary milk and cream. A patient on milk and cream rapidly develops taste fatigue, his weight may become a problem and it may be too costly.

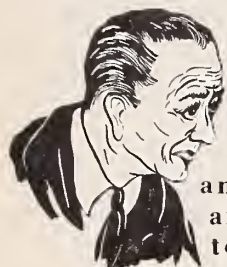
The antacid may be either an aluminum hydroxide preparation or calcium carbonate powders. To combat the constipating effect of these agents, magnesium carbonate (1 teaspoonful) or magnesium oxide heavy ($\frac{1}{4}$ teaspoonful) should be given, according to need, along with the antacid.

TABLE I. PEPTIC ULCER PROFILE

Possible Sites	Usual Sites	Major Symptoms	Distinguishing Features of Pain	Accessory Symptoms	Physical Findings
Lower esophagus	Lesser curvature of stomach	Pain	Chronicity (average duration: 6 to 7 years)	Nausea	Localized tenderness (not uncommon)
Stomach	First 3 or 4 cm. of duodenum		Periodicity (exacerbations at regular intervals)	Vomiting Constipation or diarrhea	Discernible outline of distended stomach (occasionally)
Upper duodenum			Quality (aching or a hunger sensation)	Anemia	Visible peristaltic waves (occasionally)
Small bowel*			Relationship to food intake		Palpable tender mass (rarely)

* Usually adjacent to patent gastroenterostomy or a Meckel's diverticulum.

RELIEVE



anxiety
and
tension

Anticholinergics are useful adjuncts to the ulcer program. They relieve spasm in the gastro-duodenal area and aid in keeping the acid level low. The choice of which among available anticholinergics to use for a given

patient is determined largely by patient response.

In the patient with peptic ulcer, nervousness, anxiety and tension are often characteristics of his emotional make-up. For this reason the inclusion of a tranquilizer and/or sedative in the therapeutic regimen is important. Additionally, the calming effect achieved aids the patient in developing confidence in his ability to cope satisfactorily with his medical problem. Among the newer tranquilizers, benzquinamide* — a benzoquinolizine derivative, reported to have an impressively low order of toxicity² — has proved to be one of considerable utility for the ulcer patient. This agent does not appear to induce any significant drowsiness, an advantage for these patients who are frequently in their most productive business years or in the year of greatest family responsibilities. Of equal importance is the absence of any demonstrable interference with normal physiologic processes in the gastrointestinal tract.

Shown below is an example of a treatment schedule and diet list used for *and given to*, the ambulatory ulcer patient.

Ulcer Management

REGULAR TREATMENT SCHEDULE

7:00 AM	Breakfast (see diet list)
7:30	Antacid
8:00	Milk, 1/3 glass (3 ounces)
8:30	Antacid
9:00	Milk

Continue alternating milk and antacids with milk on the hour and antacids on the half-hour until supper (at the latest by 6 o'clock) and then antacids every 30 minutes thereafter until 9 PM.

BREAKFAST

One serving of:

FRUITS

Orange or grapefruit juice
Peaches
Prunes
Pears
Apricots
Applesauce
Baked apples (no skin)

EGGS (1 OR 2)

Soft cooked
Soft boiled
Soft poached
Scrambled with milk
1 OR 2 SLICES OF
Toast and butter

CEREALS

Rice krispies
Puffed rice

1 CUP OF:

Tea
Sanka

Cream of wheat
Oatmeal
(well cooked)
Boiled rice
Grits
(well cooked)

Chocolate
Milk, cream, sugar, and
butter as desired

DINNER

SOUPS (cream or clear
broth soups):

Barley
Rice
Pea
Potato
Celery
Spinach
Lettuce
Asparagus
String bean
Carrot
Tomato

1 SERVING OF:

Baked Potatoes
Mashed Potatoes
Rice
Spaghetti
Macaroni
Noodles

VEGETABLES, strained or
pureed or cooked
until soft:

Carrots
Beets
Asparagus
Green beans
Peas
Squash
Spinach

MEAT: 1 small serving of:

Roast chicken
Stewed chicken
Broiled fish
Minced Beef or diced beef
with gravy
Small portion of roast:
lamb
beef
mutton
Broiled steak and
lamb chops may be
taken after 2 or 3
months if thoroughly
masticated

DESSERTS: 1 serving of:

Bavarian cream
Lemon sponge
Grape sponge
Blanc mange
Cornstarch pudding
Tapioca custard
Vanilla custard
Ice Cream

Sponge cake
Angel cake
Lady fingers
Arrowroot cookies
Vanilla wafers
Plain cake
Jello with whipped cream
Caramel custard
Cream cheese

SUPPER

Soup (see noon list)

Rice or
Cream of wheat or
Soft egg

Crackers or
Buttered toast

Desserts (see noon list)

(The evening meal should be small in quantity and eaten as early as possible, preferably at 6:00 p.m.)

For the patient whose ulcer is in the quiescent phase, a more varied and liberal diet is allowed. With this expanded diet, milk (3 ounces) and antacids are taken three times in the morning and three times in the afternoon; the antacids are also taken two times in the evening. Under conditions of stress or at the particular times of the year when exacerbations have previously occurred, the patient is advised to resume, temporarily, the regular ulcer management diet and schedule.

The Bleeding Ulcer and the Patient

One of the especially alarming developments is the rather casual attitude that is being taken toward bleeding ulcer. Many physicians apparently regard this complication as a minor incident. Nothing could be further from the truth. A bleeding ulcer

* QUANTRIL®

has always been — and still is — a medical emergency and an indication for immediate hospitalization. Every ulcer patient should clearly understand that hematemesis or a tarry stool is the most urgent of reasons for contacting his physician promptly.

On admission to the hospital, the patient should be typed and cross-matched for blood and his hematocrit and hemoglobin determined without delay. If the latter two indicators are below normal, whole blood should be immediately started and continued until the quantity required to restore the hematocrit and hemoglobin to normal has been given. The administration of whole blood in adequate amounts far from raising blood pressure and so precipitating further bleeding (a fallacy that appears to have a firm grip on some medical circles), may well be a life-saving measure. It is almost certain to be so for the patient with a profound initial anemia who suffers a second bleeding episode.

Carefully Watched

The patient who has been transfused must be carefully watched for indications of the need for additional blood. Both the blood pressure and the pulse must be checked every 30 minutes until both have stabilized. A fall in blood pressure below 100 mm. Hg. systolic, accompanied by a rise in the pulse rate above 120 is an indication for the immediate administration of additional blood.

It is a wise physician who, in anticipation of the possible need for surgical intervention, seeks consultation with a surgeon promptly. In this way both may observe and should surgical intervention be necessary, there is no delay. Is there a rule of thumb for surgical intervention? Undoubtedly there are several. My own is the following: If the patient becomes well stabilized on an adequate bleeding ulcer program and then has a second bleeding episode, surgery is imperative. In the case of the patient who experiences persistent oozing of blood, despite a sound ulcer management program and the use of coagulants, surgery may eventually be required. In the meantime, medical management should be given a thoroughly adequate trial.

As soon as nausea stops, the bleeding ulcer patient is placed on the following schedule. It should be noted that in bleeding ulcer, calcium carbonate should be used as the antacid.

Bleeding Ulcer Schedule

6:00 AM	Milk, 1/3 glass (3 ounces)
6:30	Antacid
7:00	Milk
7:30	Antacid

Milk and antacids are alternated until 10 PM at which time the patient is given both milk and antacid. This is also done at 12 midnight and 2 AM and p.r.n.

If the patient continues to respond well, small feedings are started. As shown in the schedule and menu below, small feedings are added daily until the patient is receiving six feedings daily. Thereafter he may go on the regular ulcer regimen used for the ambulatory patient with an active ulcer. Since bleeding episodes, like exacerbations of ulcer activity, exhibit an amazing tendency to recur at the same time of year, or in the same situation, a strict ulcer program should be observed during these periods.

Schedule for Feedings for Post-bleeding Period

Additional Feedings For Ulcer Management

Unless ordered otherwise, one additional feeding is given every other day.

For feedings 1, 2, and 3, select from the following list:

Cream of wheat	Bavarian cream
Farina	Spanish cream
Boiled rice	Lemon sponge
Rice baked in milk	Grape sponge
	Blanc mange
Soft cooked egg	Cornstarch pudding
Poached egg	Tapioca pudding
	Vanilla custard
	Caramel custard
	Ice Cream
	Whipped cream
	Chocolate sauce
	Plain jello

When four feedings are ordered, the following food may be added to the above list:

Toast	Plain cake
Toasted crackers	Str. Cream soups
Milk toast	Rice, Celery
Bread pudding	Carrot
Soft scrambled eggs	Asparagus
Soft omelet	Pea
Angel cake	Potato
Sponge cake	Spinach
Arrowroot wafers	Tomato

When five and six feedings are ordered, use food from the above list.

WHEN THE PATIENT IS RECEIVING SIX FEEDINGS DAILY HE IS THEN PUT ON THE REGULAR ULCER DIET.

Gastric Ulcer and Surgery

The medical man and the surgeon continue to debate the advisability of surgical intervention in gastric ulcer. Many authorities state dogmatically that if hospitalization and intensive medical management fail to induce healing within two to six weeks, surgery is always indicated.

Those of us who oppose this policy and feel that the individual situation dictates the need for surgical intervention, point to two deterrent factors: the mortality rates for gastric resection, and the anything-but-glowing postoperative picture for the patient. Weight loss, nausea, vomiting following even a modest food intake, intolerance of certain common foodstuffs and the postoperative development of marginal ulcers are frequently the lot of the patient who has undergone gastric resection.

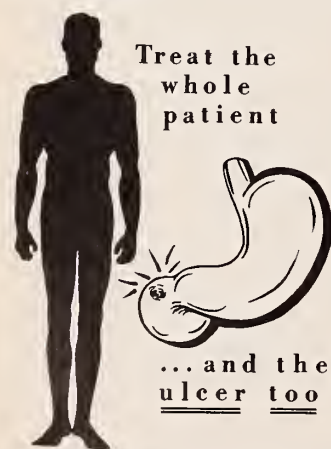
For the patient with gastric ulcer, as for the patient with duodenal ulcer, surgery should, in general,

be reserved for the handling of the complications of ulcer — namely, obstruction, perforation and bleeding.

It is important for patient and physician to recognize that the average individual with peptic ulcer is not necessarily consigned to a "blanc mange" diet for life. Rather, the patient must learn to be highly selective in the diet he follows during quiescent times and to return to his strict ulcer management regimen during those periods which experience has taught him may be associated with exacerbations. The practicability of such a plan has been amply demonstrated by physicians who themselves were peptic ulcer patients and who determined that their long-term diets should be both realistic and palatable.

Adapting the Program

Close attention should always be given to adapting the ulcer management program to the patient's life and occupation. With a little imaginative effort the physician can plan an ulcer program for anyone from a bank president to a migratory agricultural worker. If need be, powdered milk will do as well as dairy milk. Antacids can be pre-mixed and carried in a small plastic bottle or they may be taken in the form of calcium carbonate tablets. Pureed foods or finely ground foods are rarely to be found outside a hospital. The modern kitchen does not usually contain an old-fashioned colander and, in addition, the modern housewife has no enthusiasm for mashing or grinding food she has carefully prepared. As for baby foods, they are for babies and not adults. Nor can restaurants and cafeterias be counted on for any specially prepared food. Moreover, such requirements, by setting the patient apart, embarrass the patient and serve as a constant reminder that he is not in perfect health. Almost all peptic ulcer patients will do exceedingly well if their food is well done and if they take the time to chew it thoroughly.



eight weeks (and frequently the ulcer will not be

Finally, a word may be in order regarding the frequency with which radiologic examinations should be made, as a check on the results of the therapeutic program. For the young person who has experienced his first ulcer episode and is now symptom-free, X-rays may be taken in six to

demonstrable at this time) and repeated at three-month intervals during the follow-up period.

For the veteran of the ulcer wars, however, one risks unnecessary disappointment and may be incurring unnecessary expense if repeat X-rays are obtained too soon or too frequently. The first X-ray check on the results of therapy may be made as much as six months after the patient becomes symptom-free. Subsequent follow-up X-rays may be made at even longer intervals since this individual is fully acquainted with his predisposition to recurrence and will have little inclination to depart from your prescribed — and written — dietary instructions.

Summary and Conclusion

The growing trend away from complete diagnostic and therapeutic effort in patients with peptic ulcer, and the dangers inherent in this practice, are discussed. Those procedures essential to a correct diagnosis are reviewed and an optimal therapeutic program, including detailed diet therapy, as well as the management of the patient with bleeding ulcer are described.

In peptic ulcer, complete diagnostic effort cannot be limited to obtaining and interpreting physical, laboratory and radiologic findings, but must also include a thorough evaluation of the "whole" patient — his family, social and educational background, his working environment, his mental capacity and his emotional make-up.

Therapy, in turn, must be designed to provide treatment of this "whole" patient. For optimal results an ulcer management program has four parts: diet therapy, antacids, anticholinergics and, because peptic ulcer patients commonly exhibit anxiety and tension, tranquilizers and/or sedatives. Since the majority of these individuals are in their most active years of business and family responsibilities, care must be taken to select a tranquilizer that does not cause undue sedation or lethargy. An agent that is relatively free of these side effects, such as benzquinamide — a new tranquilizer of the benzoquinoline series, is recommended.

Finally, every physician treating peptic ulcer patients has three particular obligations: 1) always provide the patient with written dietary instructions; 2) make the ulcer management program adaptable to the patient's living and working environment and his economic situation; and 3) be mindful that a bleeding ulcer is not a minor incident but a medical emergency.

1467 Harper Street

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EXPERIENCES WITH MAMMOGRAPHY AT EMORY UNIVERSITY HOSPITAL

James V. Rogers, Jr., M.D., and R. Waldo Powell, M.D., *Atlanta*

*This new diagnostic technique
has proven of definite value
in the authors' experience.*

AFTER A FEW ISOLATED attempts at mammography on patients with suspected occult carcinoma of the breast, we began a concerted effort to develop a more satisfactory technique in February of 1960. At this time, both Leborgne,¹ and Gershon-Cohen² with a broad experience in this field had developed techniques which were satisfactory in their hands. Our attempts at reproducing these techniques failed to consistently yield satisfactory results. This led us to experiment with a variety of films, technical factors and positions. Although some studies were excellent, films of optimum quality were not consistently obtained.

We were becoming somewhat discouraged when Egan³ published his first article on mammography in December of 1960. On adopting this technique we began to notice a consistent improvement in the quality of the examinations with an increased diagnostic accuracy and more confidence in the procedure.

In September of 1961, one of us, along with representatives from 23 other institutions, spent a week in Egan's department at M. D. Anderson Hospital being briefed in his technique for mammography in order to participate in a reproducibility study

sponsored by the Cancer Control Program of the United States Public Health Service. As a part of this study, between September 1961, and November 1962, mammograms were made on 152 patients who had subsequently microscopic proof of the nature of their breast lesion.

This group of patients are highly select in that each patient had a breast lesion that was suspicious enough to warrant surgery. However, in each instance a preoperative clinical impression was recorded. Interpretation of the films was made without benefit of clinical information with the exception of knowing, in some instances, which breast was suspect. In Table I the results of this study are listed. An accuracy of 88 per cent was achieved.

TABLE I. ACCURACY OF MAMMOGRAPHY

	No.	%
Tissue Diagnosis	152	100
Malignant	66	43
Benign	86	57
X-Ray Accuracy	134	88
Malignant	58	88
Undercall	8	
Overcall	10	
Clinical Accuracy	134	88
Malignant	62	94
Undercall	4	
Overcall	14	
Double Undercall	2	
Double Overcall	5	

Dr. Rogers is Associate Professor of Radiology and Dr. Powell is Assistant Professor of Surgery at Emory University School of Medicine, Atlanta.

Presented at the 109th Annual Session of the Medical Association of Georgia, May 5, 1963, Jekyll Island, Georgia.

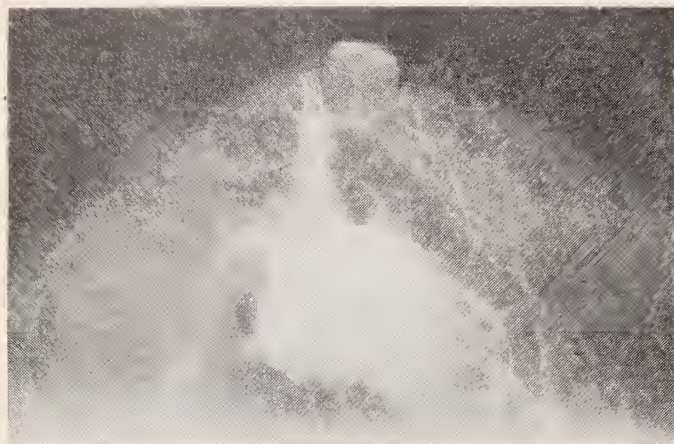


FIGURE 1.

Craniocaudal projection of breast demonstrating large mass with irregular borders and tentacles typical of carcinoma.

Discussion

The criteria for radiologic diagnosis of breast cancer have been enumerated by many investigators (Figure 1).

These include:

I. Primary Signs

- A. Mass with irregular outline, tentacles, and blurred perifocal area
- B. Mass smaller radiographically than clinically.
- C. Punctate calcifications (present in about 30%).

II. Secondary Signs

- A. Nipple deformity.
- B. Skin changes (thickening, retraction).
- C. Increased vascularity.
- D. Axillary adenopathy.

A retrospective evaluation of the inaccurate radiographic diagnoses indicates the following causes for errors:

1. Faulty technique: This includes poor positioning, motion, improper technical factors, and improper processing of films.
2. Faulty interpretation: A thorough familiarity with the radiographic anatomy, physiologic variations, and pathologic changes is essential. Accuracy

increases with experience.

3. Lack of clinical information: Deep-lying and medially located lesions are often impossible to include on the cranio-caudad view. These same lesions may be obscured in the lateral view in dense breasts.

4. Rarely, a malignant lesion will be completely missed radiographically with available techniques even though an optimum study is obtained.

At the present time we feel the following are indication for mammography:

1. Metastases with unknown primary.
2. Indeterminate mass on palpation.
3. Multiple nodules — "lumpy breasts."
4. Large fatty breasts.
5. Breast symptoms — negative palpation.
6. Mass — biopsy refused.
7. Unexplained nipple or skin deformity.
8. Clinical carcinoma of the breast.
9. Post-mastectomy follow-up.
10. Screening procedure.

Conclusions

In addition to the 152 patients in this report, we have done mammograms on about 175 others making a total of over 300 patients.

From this relatively limited experience, we have drawn the following conclusions:

1. Even though mammography was considered unreliable by most radiologists prior to 1960, recent technical improvements have occurred, and mammography now is of definite value in the diagnosis of diseases of the breast, especially breast cancer.

2. It is not perfected at the present time to the point of displacing surgical biopsy and histologic diagnosis; however, it is not unreasonable to think this may occur with more experience and further improvement in techniques.

Emory University School of Medicine

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All orders for this material should include the proper remittance, and be directed to the Order Department, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

SIMPLIFIED APPROACH TO OTITIS EXTERNA

Ben H. Jenkins, M.D., *Newnan*

***Due attention should be paid to control of moisture,
temperature, and cleanliness.***

OTITIS EXTERNA is a relatively simple thing to diagnose; however, there are few things in medicine today which are handled so badly by the physician. For some strange reason a profession which makes a fetish out of cleanliness forgets this basic precept of practice when dealing with otitis externa, and in most cases make a wholly illogical approach to what is basically a very simple problem.

Interplay

Acute external otitis results from an interplay between invading pathogens, improper response of the host tissue and undesirable factors in the environment. Often infection has occurred only because of a pre-existing disturbance of the meatal skin or environment. Adequate management must therefore take into consideration the host factors as well as the pathogens and give due attention to factors such as moisture, temperature and above all cleanliness.

Normal skin has a slightly acid pH and this is often referred to as the "acid mantle". When this acid pH is replaced by an alkaline pH, resistance to bacterial and fungal invasion is impaired. The normal ear canal has a skin pH value chiefly within the acid range, whereas in external otitis the pH usually ranges between 7.1 and 7.8, well on the alkaline side.

During the summer we find the incidence of external otitis showing a sharp increase. This particularly involves swimmers, and the term "Swimmer's Ear" has often been applied. The retention of moisture is probably to be blamed for this condition and the removal of this moisture from the infected skin is of prime importance. It therefore becomes mandatory, in treating otitis externa, to apply topical medication consisting of both a drying agent and an agent which will produce an acid pH in the external canal. The medication may under no circumstances be in a watery vehicle since this would destroy the drying action in the external canal which is so essential for a cure.

High Temperature

High temperature may also contribute to Swimmer's Ear. Senturia¹ proposes that the combination of heat and moisture causes change in chemistry of cerumen and leads to dysfunction of the ceruminous glands. This in turn would invite scratching and rubbing and predispose to infection.

The most important question to ask yourself in treating otitis externa is, does the medication reach the site of infection? It is absolutely essential that all debris be removed from the external canal as thoroughly as it is feasible before applying medication. No medication can reach the desired surface if there is an intervening layer of wax, exudate or necrotic tissue. This may be done very simply by the

¹Presented at the 109th Annual Session of the Medical Association of Georgia, May 5, 1963, Jekyll Island, Georgia.

installation of a proteolytic enzyme ointment* into the external canal for 24 hours before beginning your drop therapy. If such a layer of exudate is present, the ointment is placed in the involving external canal and left for 24 hours, after which time the ear is washed clean with warm water. When the ear has been thoroughly cleaned, I usually insert a wick into the external canal, saturated in the treatment solution, and the patient is instructed to drop the medication on the wick for the first 24 hours. Where applicable the patient is asked to return to the office after the second 24 hours so that I may remove the wick. If this is not possible, however, the patient is instructed to remove the wick, but to continue the medication in the external canal on the same schedule, four drops every three hours, being very careful to get the drops well into the canal before turning to the other side.

Acute Discomfort

The patients themselves may be in acute discomfort with itching or severe pain. These symptoms are associated with the inflammatory reaction and otitis preparations often contain topical steroids for anti-inflammatory effect. The use of steroids in this fashion, however, has a definite drawback; they mask manifestation of disease. If by chance the applied microbial agent is ineffective, the propagation of infection will go unnoticed and both patient and physician will erroneously assume that the otitis is improving. I believe this fact alone is accountable for the patient who says — I can never cure my condition, I just have to keep treating it. Eventually, of course, such treatment will always result in more extensive disease and the infection may by then prove resistant to any form of therapy. Therefore, only if one is sure about the antimicrobial agent can the less essential anti-inflammatory steroid be included.

What can be done to allay the pain which is often severe in the acutely inflamed ear? Some preparations containing local anesthetics are used, and often used successfully, but the meatal skin is prone to dermatitis reactions and the use of local anesthetics should probably be condemned because of their allergenic properties. Preferably, one should use a general analgesic such as codeine during the first 24 hours of therapy. Beyond that, inflammation and pain will have greatly subsided if the antimicrobial therapy was effective. Bearing in mind the following facts will always spell the difference between success and/or failure, of topical therapy in

the external canal. They are in brief: (1) acid pH; (2) absence of moisture; (3) reach the site of infection by removing debris, excessive wax, and by using a drop with a low surface tension; (4) avoid sensitizing agents, especially local anesthetics; (5) don't mask the infection by the use of steroids when correct choice of the antimicrobial agent is in doubt.

Most Common Cause

The most common cause of otitis externa is the Gram-negative *Pseudomonas aeruginosa*, which is involved in about 70 per cent of all cases. True fungus infections of the ear are relatively rare; among these, however, are *Aspergillus Niger* which appears to play a dominant role. But other bacteria and fungi may be incriminated, and among each species one finds antibiotic-resistant strains. Bacteriologic diagnosis and bacterial sensitivity testing is therefore theoretically desirable to guide one in the choice of the proper antimicrobial agent. However, the procedure is impractical and costly and takes valuable time before therapy is begun. This forces the physician to gamble and to pick at random from a number of preparations, hoping that his choice will indeed provide the right antimicrobial agent. Unfortunately, antibiotics, sulfas and nitrofurans, while very potent, have limited antimicrobial spectra; and they may sensitize the meatal skin. New antibiotics which prove effective today may no longer be effective tomorrow because of the emergency of resistant strains.

It has been my experience in well over a thousand cases, that the use of sulfonamides, antibiotics, and steroids are not really necessary in the treatment of external otitis. In the pre-antibiotic era we relied on preparations containing acetic acid and alcohol. The acidifying and antifungal properties of acetic acid, combined with the disinfecting and drying action of alcohol usually resulted in effective therapy. My experience has shown this method of treatment to be superior to any antibiotic preparation both with regards to effectiveness and absence of side reactions.

Solution Used

In the solution used, as a drop, acetic acid was retained as the organic acid. Acetic acid is well tolerated by tissue cells, while many bacteria and fungi are unable to metabolize it. Its merits are not due solely to its acidity; at equal pH, acetic acid shows considerably greater antibacterial properties than mineral acids such as sulfuric acid.²

Propylene glycol (propanediol) was chosen instead of ethyl alcohol because of its slower evaporation and because of its cerumen softening action.

By adding a propanediol diacetate ester, a stable system is formed containing two per cent acetic acid,

* Chymar Ointment, Armour Pharmaceutical Co., Chicago, Ill.

** VoSol Otic Solution, Wampole Laboratories, Stamford, Conn.

three per cent of ester, and 95 per cent of propylene glycol. When in contact with moisture, the ester slowly picks up water and releases acetic acid and propanediol, thereby keeping the degree of acidity fairly constant.

The antimicrobial and antifungal range of this system is so complete that as yet no resistant organism has been isolated.³

I discussed my observations with this preparation in 1961 and again in 1962.^{4,5} As stated previously, my experience now extends to well over a thousand cases and results have been good without exception when patients were properly selected and when adequate exposure to the ear solution had been assured. In those cases where an underlying dermatosis was a contributing or primary problem, one per cent hydrocortisone was added to the preparation.***

Recurrent Flare-Ups

It is known that many swimmers and campers, and certain workers employed in industry have recurrent flare-ups of external otitis. We have long sought a suitable preparation for prophylactic therapy. Senturia et al.,¹ for instance, tried to formulate a wax for this purpose since they felt that recurrent otitis externa was due to a deficient wax composition. As yet this has not resulted in a useful medication. Others have resorted to antibiotic and steroid containing preparations, but obviously these are not suitable for prophylactic therapy, inasmuch as their

*** VoSol-HC Otic Solution, Wampole Laboratories, Stamford, Conn.

prophylactic use would invite sensitization and emergency of resistant strains. In contrast, the here presented formulation can safely be used day after day and retain its effectiveness while giving adequate protection. Extensive trials in several thousand campers and swimmers were done by Langston⁶ and Struhl.⁷ They both confirmed the applicability of this concept and achieved virtually complete absence of otitis in their study groups.

Conclusion

Most otitis externa may be easily treated or controlled by first, gentle cleaning of the external canal, when applicable with the proteolytic enzyme; and secondly, the installation of the acid alcohol preparation as described. Failure using this method will almost always be due to the inadequate cleaning of the external canal and the inadequate installation of the acid alcohol preparation.

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A.M.A. TO PUBLISH MEDICAL MOTION PICTURE CATALOG

The American Medical Association announced today it will publish an indexed catalog listing more than 4,000 medical motion pictures, covering every aspect of medicine and its allied arts. Expected release date of the catalog is late 1963.

Motion pictures are a highly important tool in the training of graduate physicians, students, nurses and all others concerned with the healing arts.

Ralph P. Creer, director of medical motion pictures and television for the A.M.A., said the new catalog will list each film with a brief summary, running time, names of authors and producers, and address of the primary rental source. Evaluations will be included with many of these films.

Publication format was established by a discussion between representatives of the A.M.A., the American College of Surgeons, the International College of Surgeons, the Association of American Medical Colleges,

the American Hospital Association, the American Dental Association, the United States Veterans Administration, E. R. Squibb and Sons, and Smith, Kline and French Laboratories.

The A.M.A. maintains the most complete file of information on medical motion pictures and for many years has been receiving requests for copies of this file. It will now be used to prepare this comprehensive catalog of medical motion pictures which will be available to medical schools, state and county medical societies, hospitals, medical educators, nursing organizations, government agencies and other professional groups and individuals.

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HYPOTHERMIA IN GENERAL SURGERY

B. A. Addison, M.D., and E. R. Jennings, M.D., *Brunswick*

*Clinical experience with 126 patients is
discussed by the authors.*

HYPOTHERMIA is defined as the deliberate reduction in body temperature in man for therapeutic purposes. Actual clinical application of body cooling ranges from just below normal to almost freezing. Because of this wide range of use, hypothermia has been arbitrarily classified as moderate, intermediate and deep. Moderate hypothermia refers to cooling from 98°F and this general range has proven effective without the disadvantages attendant with lower temperatures. On our general surgical service, moderate hypothermia has been used in 126 patients. Impressions derived from this experience have led us to advocate this modality as a reliable and essential technique.

Physiology

In general, hypothermia causes a fall in the metabolic rate of all the tissues of the body. Gordon et al¹ found that oxygen consumption in the dog was 50 per cent of normal at 87°F. With the lowered metabolic activity, changes have been recorded in the nervous, cardiovascular, respiratory, biliary, gastrointestinal, renal and endocrine systems. A reduction in blood flow and a decrease in size of the brain is accomplished. The heart rate falls and there is an initial constriction of the vascular tree. Hypothermia depresses spontaneous respiration, causes bronchodilatation, and usually ends up with normal

ventilation.² Hepatic blood flow is diminished but liver protection is afforded by body cooling.³ Marked reduction in pancreatic secretions has been noted.⁴ There is decrease in the production of pepsin and hydrochloric acid in the stomach during hypothermia. Renal blood flow is depressed but urine volume remains normal or increases. Moderate hypothermia has been shown to double the safe period for vascular occlusion of the kidney.⁵ Adrenal cortical secretion is decreased but increased amounts of epinephrine and nor-epinephrine are present.⁶

Reduction of Pain

Hypothermia also has been found to frequently decrease pain. Allen et al⁷ found that there was a retardation of bacterial metabolism and growth with little or no change in the body defense mechanism.

On the basis of the known changes affected by hypothermia, potential applications in a variety of conditions is evident. We have thus utilized this modality in two general classes of patients. (1) In conjunction with operative treatment in the poor risk patient or the patient in which the risk could be diminished; (2) In an acute or reversible condition causing hypoxia or hyperpyrexia. Realizing the effects of hypothermia on the various body systems one readily individualizes each seriously ill patient with these facts in mind.

In our hands, the preferred method for cooling is with a cooling blanket. This blanket is made up

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of inner parallel lengths of rubber tubing which are supplied with temperature controlled water. This allows high volume, low pressure water flow for adequate heat exchange. The water is cooled and heated by a thermostatically controlled unit with ranges from 40°F to 110°F.

Technique

The technique of clinical application consists of first preparing the patient by padding all pressure points such as elbows and heels. A rectal telethermometer lead is inserted and the patient wrapped in a cooling blanket attached to the hypothermia unit. The temperature is set at maximum cooling. The patient is either anesthetized or adequately sedated. Shivering in the non-anesthetized patient is usually controlled by a phenothiazine derivative intravenously. Hydration is well maintained and good respiratory exchange is accomplished by positive pressure breathing at intervals. The temperature of the patient is continuously monitored. The blood pressure is carefully observed and frequently a cardioscope is used for monitoring the electrocardiogram. Frequent turning, adequate respiratory assisting, control of shivering and realization of temperature drifts are important points in management.

Maintenance of Temperature

Once the desired temperature range is reached, the patient's cooling is usually maintained by a moderate water setting. When hypothermia is no longer required, the temperature setting is slowly increased and the patient is allowed to return to a normal temperature range. Occasionally the patient's condition will deteriorate on rewarming and repeat cooling will be necessary. Because of varied conditions which the general surgeon is called on to treat, a general division of types of surgery is given.

Neurological Surgery

Our experiences are limited to traumatic neurosurgery. All severe head injuries have been treated with hypothermia with or without decompression. In addition, several spinal cord injuries have been subjected to total body cooling. Impressions derived from 45 cases suggest that hypothermia is an extremely important protective mechanism in the acute head injury and is of little value in the cord injury.

Cardiac Surgery

Combined hypothermia with extracorporeal circulation has been used in selected cases with congenital and acquired heart disease. Because of lower tissue requirements, adequate perfusion and oxygenation with minimal blood utilization have been obtained. Postoperative normothermia has been maintained by cooling blanket stabilization in many cases. Inter-

trial septal defect, pulmonic stenosis, interventricular septal defect, tetralogy of Fallot, mitral and aortic valvular disease have been successfully corrected by combined heart lung machine and hypothermia. Closed heart surgery has for the most part been done without hypothermia. Thirty-two cardiac cases have been done with adjunctive hypothermia.

Abdominal Surgery

Hypothermia has been used in 47 cases of abdominal surgery. The regional vasoconstriction, decrease in gastric acidity and decrease in mean arterial pressure have seemed to have a definite therapeutic effect on upper gastrointestinal bleeding in eight cases. The protective mechanism to vital organs in the event of sudden vascular collapse has seemed to be augmented by hypothermia concomitantly with restoration of blood volume.

It is interesting to note that total body cooling has been used in four cases of severe pancreatitis with salvage of three acutely ill patients. Symbus et al⁴ state there is definite decrease in pancreatic secretion, at moderate hypothermia levels. Our clinical experience to date seems to confirm these findings.

In cases of severe liver damage, either due to cirrhosis, or patients with obstructive jaundice, surgery has been implemented with moderate body cooling. Three porto-systemic shunts have been performed and eight cases of obstructive jaundice have been corrected under hypothermia.

Severe infections such as acute peritonitis and cases of septic shock due to septicemia respond better to therapy when hypothermia is used with the usual therapy. Allen et al⁷ state that there is a marked decrease in bacterial activity at moderate hypothermic temperatures with no obvious decrease in the body defense mechanism.

We have been impressed by the clinical response to peritonitis due to perforated ulcer, ruptured diverticulitis, ruptured appendix, and gangrenous bowel. Twelve cases of severe peritonitis have been subjected to lower body temperature in conjunction with appropriate surgery. In addition, six cases of septic shock due to a variety of causes have been treated.

Vascular Surgery

In certain types of vascular procedures, hypothermia is of definite benefit. It has been used as an added protection in severe carotid endarterectomies in which carotid angiography revealed the opposite carotid vessels to be partially occluded. With this technique the carotid has been occluded as long as eight minutes, without evidence of cerebral damage. We feel this technique gives an added margin of safety in these cases with bilateral carotid insufficiency.

In procedures on renal vessels in which the blood flow must be occluded for any significant length of time, Steuber⁸ and his group showed experimentally that hypothermia was of great benefit. We have successfully used hypothermia in a ruptured aortic aneurysm in which renal occlusion was required.

Roberts⁹ et al summed it up as follows: "There are not many procedures in peripheral arterial surgery in which hypothermia is required, but when an operation is performed upon the blood supply of any vital organ in which ischemia is poorly tolerated, hypothermia may be of help."

Summary

Clinical experience with 126 cases in a general surgical practice reveals that hypothermia is an extremely useful adjunct in the treatment of many conditions.

Moderate hypothermia by means of surface cooling has resulted in an improved safety factor in op-

erative procedures; and in general has seemed to salvage lives otherwise thought to be lost.

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DOCTORS HOLD FIFTH ANNUAL WASHINGTON LUNCHEON

For the fifth year straight running members of the Medical Association of Georgia have participated in an annual Congressional Luncheon for members of the Georgia delegation in the Congress. Each year since 1959 MAG has been host at a "thank you for a job well done" luncheon for our House and Senate representatives and the most consistent thing about these affairs is that they seem to improve each year.

Objectives

These once-a-year luncheons have several objectives not the least of which is the improvement of relations and the betterment of understanding between Georgia physicians and the Georgia delegation in the House and Senate.

On these two points our luncheons have never been anything but a success and 1963 was no exception. As a purely public relations proposition, our annual Washington trip is the equal of any event on the MAG yearly calendar of events.

This year's luncheon was held on May 23rd in the Speaker's Dining Room at the U.S. Capitol in Washington. It was arranged through the good offices of Congressman Robert G. Stephens, Jr. of Georgia's Tenth Congressional District.

Our State's 12 man delegation and their wives were extended invitations and all of those present in Washington on the appointed date were with us for lunch. All except one that is. Senator Talmadge was unavoidably detained in a meeting of the Senate Finance Committee and could not join our group.

Prior to making the rounds of the Congressional offices, the MAG delegation paid a call on the Washington office of the AMA for a briefing on any and

all late developments concerning social security medical legislation and on other matters of general importance. Here our group was given an "eagle eye" account of the situation by a team of experts on Washington affairs. Following the briefing, doctors in pairs and fours called on their respective Members of Congress for informal talks concerning King-Anderson and other issues. At 12 Noon we gathered in the Speaker's Dining Room for lunch and an exchange of views with our Congressional delegation.

In the past, these luncheons have been strictly stag affairs. This year something new was added and from all indications it added zest and color to the occasion. Unlike our previous four luncheons this time the wives of the Congressmen were invited to attend, and to compliment this arrangement those doctors making the trip were encouraged to bring their wives also.

Progress Report

Our Representatives listened attentively as the progress of Kerr-Mills in Georgia was explained and they were moved to comment freely on their hope that it could do the job of providing needed care of elderly persons. MAG President Dillinger invited them to send him any letters they may receive from constituents complaining of lack of medical care. He promised that MAG would look into any such case with a view toward amelioration of legitimate complaints. This gesture was enthusiastically received by our Congressmen.

During dessert and coffee each Congressman and his wife was introduced by his constituent physician-host and asked to say a few words to the group. The general theme of remarks made left little doubt as to the value of these annual Congressional trips.

SOCIALIZED MEDICINE

James W. Harkess, *Augusta*

Observations of a physician who elected to repudiate "the scheme" in Great Britain.

THE LAST TWO GREAT world wars have been followed by a period of idealism during which popular sentiment has demanded a change from the bad old ways so that everyone should live a fuller and happier life. After the last war the British, like the Americans, wanted to make their country a place fit for heroes to live in. The dreary years after the depression during which many families lived at the starvation level were followed by the privations of a long and vicious war. People were ready for a new approach to their problems and the country was ripe for socialism. Even when the war was at its height in 1942, the government ordered a study carried out by Lord Beveridge which was to provide a blueprint for future legislation designed to eliminate poverty and disease.

For Everyone

Obviously in this utopia of the welfare state, comprehensive medical care would have to be provided for everyone. This was accomplished by the National Health Service Act of 1946, and in 1948 socialized medicine became a reality.

During this period I was a young and rather ingenuous medical student and mine was the first graduating class to enter the National Health Service, unsullied by the crass commercialism of private practice.

Socialized medicine had no more enthusiastic advocate than myself. After all the government had promised that all types of medical care would be freely available to everyone regardless of their income. This covered not only the services of the family doctor but also hospitalization, drugs, prostheses and even, indeed, spectacles and wigs. Now that the government had taken over, we would see an end of the snake-pits run by some of the local authorities. The poor old voluntary hospitals which badly needed funds would have the money to refurbish their deteriorating fabric and to buy the modern instruments necessary in a first-class hospital. Not only that, there would be an end to the family doctor practicing in a room of his own house because eventually he would have his own quarters in domiciliary health centers, complete with X-rays and laboratories so that he, too, could practice first-class scientific medicine. It seemed to me that this was the start of the new millennium. Now we could succour suffering humanity and stamp out disease. It is said that a young man who isn't a Communist has no spirit and, alas, an old man who is one has no sense.

Grandiose Designs

Why then have I turned my coat? The grandiose designs of the National Health Service just have not transpired. This has been due not to the perfidy of politicians but to the hard facts of economics. The country just couldn't afford it. The planners of the

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National Health Service like many other enthusiasts erred on the optimistic side when they calculated cost. After the first nine months of 1949, parliament was asked for a 53 million pound supplementary estimate to finance the health service, and in 1950 the budget had to be supplemented by a further 96 million pounds. The Chancellor of the exchequer at that time set a limit of 400 million pounds, which is approximately \$1,120,000, above which the cost of the National Health Service might not rise. However, in spite of this, the costs have continued to rise so that in 1960-61 the cost of the clinical services was almost two and one half billion dollars.

People set the value of a commodity at the price they have to pay for it or how hard they have to work for it. The National Health Service ostensibly costs the consumer very little and it was used accordingly. Alternatively, I suppose, people felt that having paid their weekly contributions they were entitled to service and they were going to get their money's worth.

Eventually the government tried to minimize this excessive utilization of services by levying charges on drug prescriptions, dental care, etc. Initially a prescription cost one shilling (14¢) and now the charge is two shillings. The main economies, however, were made at the expense of the employees of the health service and by the curtailment of capital expenditures.

Specialty Training

Many of the young doctors returning from the war were encouraged to train in a specialty. They were told, "We are going to have the best medical service in the entire world. This will require specialists and so we are willing to subsidize your training." However, after completing their training these specialists were all dressed up with nowhere to go. There just wasn't enough money to pay these men as full consultants, so they became superannuated registrars or were given the temporary classification of senior hospital medical officer. This peculiar animal was neither fish nor fowl, and did a consultant's work without a consultant's pay.

Few if any new hospitals have been built since the inception of the scheme and the large majority of hospitals in Great Britain are more than fifty years old. In 1962, with much fanfare, a new program of hospital building was announced. Let me quote a paragraph from a letter in the *British Medical Journal* regarding this.

"Sir. To many of those familiar with the hospital service, it has seemed that the recent White Paper on hospitals was designed more for political impact than to effect significant re-

form of hospital building. A great deal has been written about the planned expenditure of 500 million pounds in the next ten years, but few people realize how relatively little this will achieve. Roughly 35 million pounds expenditure is planned for the present financial year, but, in terms of pre-war values, this represents less than was spent on hospital building in 1938. In fact, it is only slightly more than the cost of erecting the new Shell Mex Building in London. Moreover, it is likely that increased building costs will render even the planned peak expenditure (50 million pounds per annum), little more than was spent before the last war. With 23 years of backlog to make up, and with so many of our hospitals in a state of extreme dilapidation, it is surely necessary to spend much more money on them. If the money cannot be made available by the Treasury, then it is high time that we explored alternative means of raising the necessary funds."

Apprehension

As physicians we are naturally apprehensive regarding our role in a socialized system. Some of the fears of our British colleagues were allayed by the so-called Spens' Report which guaranteed the participating physicians the same relative economic position which they had enjoyed prior to socialization. This in point of fact has not been honored, although very recently, after prolonged bickering with the government over the years, a pay boost has been granted to the doctors. Judging by the correspondence in the *British Medical Journal* there are a considerable number of doctors who are most unhappy with the present system of remuneration. As you know, general practitioners are paid on a basis of how many patients they have on their books. This number of patients, however, does not equate with the amount of work these men actually carry out. Obviously, the service required by 1000 patients will vary greatly in various regions of the country according to the age distribution of the population, the climactic conditions and how widely dispersed is the population. There appears to be a widespread sentiment in favor of a fee for service system such as is currently operating in Sweden.

The specialists working in hospitals are paid either by a salary if they are full time or according to the number of sessions they perform if they are part time. However, certain of these specialists have their income augmented by "Merit Awards" for outstanding service. These awards are made by a committee, but how and why they arrive at their conclusions and to whom these awards are given is kept secret. Truly, a most unsatisfactory state of affairs.

There is no question in my mind that medical practice in Great Britain is less attractive than it was formerly. In spite of official denials to the contrary, substantial numbers of young physicians are emigrating to other countries, as are doctors of philosophy, and for the same reasons. I think that an expression of this trend is the fact that 41 per cent of all junior hospital posts are held by overseas doctors. The large majority of these trainees will return to the countries of their origin so that the pool of potential consultants has shrunk while the population in general is increasing. Another aggravating factor is the Willink Committee's findings six years ago that Britain was producing too many doctors. They recommended a cut back in the number of medical students. Now the cry is, "We need more doctors in order to reduce the lists of the family doctors so that they can do a better job."

Something for Nothing

In a recent television program about the National Health Service, it was said that 80 per cent of the people in Great Britain are very happy with the present system. This is not surprising since most people are delighted with something for nothing. Not many people would buy a Cadillac when Chevrolets were given out free!

It is true that anyone suffering from a catastrophic illness or anyone who requires emergency surgery will be admitted to hospital and have excellent care. However, how does the patient fare who has some uncomfortable chronic condition which doesn't endanger his life. What about the patient with hemorrhoids, or a hernia, or perhaps chronic gall bladder disease requiring elective surgery. These patients will be placed on a waiting list and might have to wait several months or even years before a hospital bed becomes available to them. What happens to the person who requires a specialist's consultation? A recent paper published in the *British Medical Journal* shows that in one region of Scotland it takes an average of 19.7 days between the referral of a patient to a hospital out-patient department and the receiving of the report by the family doctor. It is for these reasons that an increasing number of middle class patients are turning their backs on free medicine and are paying doctors privately.

Rising Figure

In 1950, 100,000 people in Great Britain were covered by private health insurance and this figure has risen to over 1,000,000 at the present time. In financial terms, this insurance cost 200 thousand pounds in 1950, and this figure has swelled to over five million pounds now. One would be very ingenuous to suppose that private patients pay good

money for something they are entitled to have free. It follows that they must derive some additional advantage by being a private patient. This leads to the inescapable conclusion that private medicine is better than socialized medicine.

Payment for Drugs

These poor private patients not only have to pay for their doctor but also for their drugs. The recently published Porritt Report suggested that private patients, like others, should be given their drugs free. Lady Summerskill, a doctor-politician, regarded this proposal with disdain. She said that if this were done it would undermine the whole structure of the health service, because it would establish two categories of patients within the service. It really isn't very difficult to see why England could produce a Lewis Carroll.

Many of our professional brethren in the United Kingdom are somewhat ambivalent about the National Health Service. While they grumble about it a great deal themselves, adverse criticism from the American medical profession causes their hackles to rise. Writing in the *British Medical Journal* under the pseudonym of Pertinax, one of our colleagues wrote, "I see that President Kennedy has recently put before Congress a revised program of Health Care for the Aged. I am not surprised to read that the American Medical Association is still bitterly opposed. This is the AMA's affair and I don't want to voice any opposition to its opposition to something it doesn't like, but I do hope the AMA won't buttress its case by misleading references to Britain's N.H.S."

Problems

Let us therefore forget about England's troubles and concentrate on our own. Under any system, socialized or otherwise, there are certain irreducible costs. Drugs must be paid for, hospitals built and maintained, and personnel employed to run them. Why add to these costs the expense of a cumbersome and inefficient bureaucracy which is entirely unproductive as far as the healing or prevention of disease is concerned. We are all well aware that our tax dollar on its journey to Washington and back shrinks on the way due to administrative costs.

Recently in a debate on the welfare state, a rather liberal professor of economics told me that medical men are extremely naive when it comes to economics. He could see no difference between socialized medicine and prepaid medical care such as the Blue Cross-Blue Shield system. Unsophisticated as I am about these matters, I understand the difference between an insurance premium and a tax. I further believe that the best way to ruin incentive or productivity is to raise taxation.

The thesis that the government can run industries more efficiently and cheaper than private enterprise is another liberal pipe dream. The steel industry which was nationalized in Great Britain was almost ruined by nationalization and eventually was returned to private enterprise. One has only to look at agriculture to see that government in this country has no greater divine inspiration. I have no doubt that if we ever do have socialized medicine that the stage will be set for a medical Billie Sol Estes.

When you get right down to it, medicine is a product or a service just like automobiles from Detroit or garbage collection. The difference is that nobody wants to be sick and most people resent paying their medical bills. To feel that socialized medicine doesn't cost anything is a mirage. Sooner or later somebody has to foot the bill.

Essential Service

Some people would have us believe that medicine should be nationalized because it is an essential service. To carry this argument to its logical conclusion we should then have to nationalize the farms and supermarkets too, because it is certainly more important that we should eat every day than be seen by a doctor. The name for this type of system, of course, is Communism.

I do not dispute that there is a place for socialized medicine. In certain backward countries of Asia and Africa it is the only way that medical care can be brought to large numbers of very poor and uneducated people. This type of medical care, is somewhat Spartan by American standards and I doubt that the average matron in this country would relish the excellent medical attention given to the in-

habitants of Equatorial Africa. In this rather opulent and affluent society in which we live, people demand much greater comforts than a stripped-down economy service would provide. It is only right that these people should also pay for these frills.

I don't mean by saying this that only those who can afford to pay should be given medical treatment. Certainly the indigent should have free medical treatment, but this should not be the excuse for foisting socialized medical care on everyone. I believe, like Jefferson, that the government should only do for people that which they cannot do for themselves. With the full implementation of the Kerr-Mills Bill, the Crippled Children's Services as well as the many hospitals whose primary aim is to care for the indigent sick, I feel that there are few people in the United States who are denied adequate or even excellent medical care. If there are patients who are not so covered, I am sure that the medical profession in conjunction with federal and local government agencies can work out some means by which these unfortunate people can be treated.

Medical care of itself, no matter how excellent, does not produce prosperity. If the government would devote its energy to improving the economic lot of the people, it would seem that the need for socialized medicine would disappear.

In the early days of the colonization of Australia, certain misguided emigrants imported sparrows, rabbits and thistles to make their new country seem more like home. Each of these proved deleterious to the ecology of Australia, and the government spends millions trying to control the rabbits alone. I feel that the sparrow of socialized medicine might be equally disastrous if imported into this country.

Medical College of Georgia

IMPROVED BLOOD PRESERVATION REPORTED

Improved blood preservation by refrigeration in a CO₂-rich atmosphere was reported by the head of a blood bank at the New York State Medical Society's 157th annual convention.

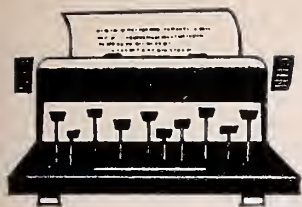
The method could make it possible to extend the current 21-day storage limit and cut down the "tremendous waste of outdated banked blood," said Dr. John Scudder, blood bank director at Presbyterian Hospital and Associate Professor of Surgery at Columbia University College of Physicians and Surgeons.

Dr. Scudder pointed out that CO₂ storage retards ammonia formation, and, "it has been established that,

when ammonia concentration increases, banked blood becomes less stable and commences to deteriorate earlier."

He describes results of a 60-day trial last fall on blood stored in the hospital's two refrigerators, one with CO₂ added, the other without. Blood preservation was "obviously enhanced" by the CO₂ atmosphere of the first refrigerator, he said. The supernatant plasma remained clear longer with no hemolysis; strings of fibrin or denaturation products were absent, and the hemaglobin was present in the reduced form.

Medical Tribune—World Wide Report, June 3, 1963.



The Frank H. Neely Nuclear Research Center

ON THE COVER is a photograph of the nuclear reactor containment vessel of the recently dedicated Frank H. Neely Nuclear Research Center at the Georgia Institute of Technology, Atlanta.

This should be of particular interest to the physicians of Georgia and surrounding states for several reasons.

Biomedical Facility

The foresight of the Board of Regents insured the inclusion of a Biomedical facility which will make it possible for physicians to have available research facilities such as exist in only two other locations in the United States.

In addition to office, laboratory and animal facilities, a port has been provided on one face of the reactor which may be used for the irradiation of man and animals with various radiations as well as by thermal neutron capture. The latter radiations will permit the further investigative exploration of the potential use of neutron capture therapy which offers an ideal method for producing ionizing radiations within a tumor.

Short half-life isotopes will be available as well as the neutrons for use in thermal neutron activation analysis.

These facilities will be available to physicians and scientists who are interested in a particular project. Supporting facilities and consulting scientists with varied interests will be available for assistance in project work.

We are unusually fortunate in having the state of Georgia provide the scientific community with such an elaborate and important investigative tool. This should greatly augment the progress of scientific endeavor in the nuclear and space areas.

It is hoped that the physicians of the state and nearby states will support this facility by utilization and encouragement to young potential scientists upon whom we are so dependent.

In the near future you will receive a copy of the *Research Engineer**, published and contributed by the Georgia Institute of Technology, containing eight articles which cover many aspects of the Tech Reactor project. This includes the historical development of the reactor project which was initiated in January 1955. This was culminated by the dedication of the reactor in January 1963. Detailed drawings of the facility are included which show the biomedical facility and laboratory space. One article is written by the Radiation Safety Offices outlining the safety factors involved which permit control of the reactor.

Uses

The application of the reactor in the biomedical field is described briefly. The use of the reactor in the study of radiation chemistry is discussed in addition to an article on the use of the reactor in the study of high temperature materials.

The application of the reactor in biology is described.

The study of nuclear forces and structure and the expanded research potential in solid state sciences is discussed.

It should be apparent that we are in a new era and require the tools for development of our potential in technological development. The nuclear reactor facility will bring us nearer to our goal.

John T. Godwin, M.D.

* The American Cancer Society, Georgia Division, kindly distributed The Research Engineer to all physicians in Georgia.

Operation Hometown

*"The triumph of evil requires
only that good men do nothing."*
Edmund Burke, British Statesman (1727-1797)

DURING THE 1962 legislative year the King-Anderson social security medical bill was generally regarded to be the Administration's number one domestic issue pending in the Congress. King-Anderson legislation has been nudged out of first place this year by the possibility of tax cuts and tax reforms. The net result of this switch in priorities is that the individual medical practitioner has been somewhat prone to relax his guard and look once again to the AMA to carry the fight against King-Anderson type legislation for him.

Since last year's Senate vote on the Anderson-Javits substitute for King-Anderson, there has been a minimum of activity by opponents of this measure. The feeling persists in many quarters that during these "slow periods" there really isn't much to do but keep our powder dry and sit tight until this issue rears its ugly head once again. This is fallacious reasoning and nothing could insure defeat either faster or more completely than to assume that between battles we have no work to do on the home front.

No Bars Down

The Administration and kindred spirits throughout the land have never for a second relaxed their drive to whip up support for this bill. Their insistence on having statutory authority to shower hospital, medical and nursing home benefits on everyone because admittedly a few need assistance, goes on unabated. This is roughly in the same category as that of a man who uses a sledge hammer to swat a gnat.

The ready willingness of proponents of this bankrupt scheme to plunge the country further into debt and add greatly to the mortgaged future of generations yet unborn remains unchecked. And wrapped securely in this paternalistic ball of wax is the threat of bringing the medical profession into the paralyzing embrace of a super bureaucratic government. Failure to recognize these basic facts is to invite swift and total disaster.

If we are agreed on the presence of the problem, the question then becomes, what are we going to do about it. Or more specifically, how shall we organize for the most effective defense against this insidious, politically inspired program.

Course of Action

Those who attended the recent Annual Session of MAG at Jekyll Island had an opportunity to see an excellent film which outlined a specific course of action on this issue. Dr. Edward Annis, President of the American Medical Association, laid out a seven-point program called "Operation Hometown" and combined his explanation of this program with an eloquent plea for greater physician participation in a grass roots level effort calculated to insure victory when this bill is finally voted on by the Congress.

At the risk of over simplification, "Operation Hometown" can best be defined as an effort to fight the King-Anderson battle in 435 separate congressional districts all over the country. As the name implies, "Operation Hometown" is a local effort. It is the application of a massive campaign reduced in size to get the job done on the County Medical Society level. In short, it is an organized, systematized campaign designed to gain the support of your congressman in your fight against King-Anderson type legislation.

Seven Project Areas

To do this job expeditiously and effectively, "Operation Hometown" was organized into seven project areas, each representing an area of vital concern in the total defense picture. These seven project areas are: (1) formation of a Speaker's Bureau to supply speakers to non-medical groups on the subject of social security medicine and health care for the aged in general, (2) enlisting of support from friends and allies, of which there are many, (3) distribution of pamphlets and other materials to tell our side of the story, (4) informing newspapers and

radio and television stations to effectively counter the biased press "hand outs" of the proponents of this scheme, (5) organizing letter writing campaigns to members of Congress and to the newspapers, (6) personal contacts with members of the House and Senate for factual presentation of matters relative to this issue, and (7) the coordination of all these projects under the direction and guidance of a County Campaign Chairman.

This sounds like an overwhelming job, all but impossible on the local level. Actually though, when the various projects in the campaign are parcelled out among the members of the County Medical Society and the Auxiliary, the task becomes much simpler and much easier to accomplish.

The Voting Precincts

We must understand that social security medical legislation cannot be beaten in Chicago or Atlanta or by the AMA office in Washington. It can be beaten and will be beaten only in the voting precincts of the several counties that comprise the individual congressional districts across the country. Our task, though it may appear massive, is actually quite simple. What we must do is build a broad base of public disapproval for legislation of this type. We must make certain that the entire community knows what is at stake in this bill. No one must be left uncertain as to what this legislation will cost both in terms of increased taxes and more importantly in terms of its ultimate impact on the quality of medical care.

Medicine's voice alone is but a small one. It must be amplified many times by the support of friends and allies if it is to be heard over the noise of the opposition. Physicians must take the initiative and gain the support of other community leaders or we

may well be at the beginning of the end of medical practice as we have known it.

"Operation Hometown" would be incomplete if it were nothing more than a negative or defensive project. However, this is not the case. The final and perhaps the most important aspect of "Operation Hometown" is the expansion of Georgia's Kerr-Mills program to implement the features of the MAA portion of the law. The MAA phase of the Kerr-Mills program in Georgia would provide health care benefits to the medically indigent or near-needy senior citizens of our State. The medically indigent, or the near-needy as they are more often called, are defined as those persons who can live independently, but who in times of catastrophic illness would need financial assistance.

The first phase of Kerr-Mills in Georgia has been activated and is now providing hospital and nursing home benefits for approximately 100,000 aged persons who are eligible for Old Age Assistance. There is no need for additional legislation for the implementation of the MAA phase of Kerr-Mills. Authority to activate this program was part of the original legislation under which our present OAA Kerr-Mills program operates. The only unmet need is state money with which to match a federal grant-in-aid to fund this project.

MAG urges all physicians to write Governor Sanders and apprise him of the need for an expansion of Kerr-Mills in their respective areas of the State. This is our best answer to federal schemes of the King-Anderson type now pending in the Congress.

Doctor, the whole load is on your shoulders. You can ignore it and suffer the consequences, or in a manner that is characteristic of the profession, you can roll up your sleeves and beat those who would sacrifice you and the future of medical practice. We've done it before and we can do it again.

Georgia School For The Deaf

THE GEORGIA SCHOOL FOR THE DEAF, tenth oldest training center of its kind in the United States, was founded and located in the beautiful valley between Rome and Cedartown, at Cave Springs, in 1846. It has been in continuous operation since that date, except during the years of the War Between the States, when it served as a hospital for each side. It is one of Georgia's little heralded, but nationally outstanding educational institutions with a paramedical aspect.

Its progress now sparked by dynamic superintendent, Fred L. Sparks, Jr., and capably principled by John L. Caple, each a leader in this field of education, it has grown to approximately 430 students (290 white, 140 colored) and 90 teachers and employees.

Under the direction of Dr. Claude Purcell, State Superintendent of Schools, and Dr. A. P. Jarrell, Director, Vocational Rehabilitation Services, there has been almost continuous increase of specialized

personnel and construction of new buildings and facilities during the past several years, so that now the School can boast of the latest teaching methods and equipment.

The 1962-63 school year has seen the first concerted drive in the history of the school to perform complete physical and psychological examinations of all students.

Through Georgia's Department of Public Health, Dr. John Venable, Chief, the plan has been devised and carried out by Director of School Health Serv-

ices, Dr. Virginia McNamara and her staff, together with the statewide cooperation of Pediatricians, Otologists, Ophthalmologists, Audiologists, Psychologists, and Sociologists, so that 98 per cent of the white students (the Negro students are to be examined in 1963-64) have been examined and the results accurately recorded.

With all these activities, we realize that no school for the deaf could grow in stature and service without those whose lives are dedicated to the almost insurmountable tasks of counseling and directing the scholastic accomplishments of the deaf children, the Teachers of the Deaf.

Lester A. Brown, M.D.

Freedom With Responsibility

IT IS MY BELIEF that one of the biggest faults of most Americans today is that they are willing to enjoy the privileges of being free as long as there are no strings of responsibility attached. A person's country, a person's liberty, a person's God all seem to have one thing in common: each carries a responsibility—a responsibility that is shunned by the individual. All the individual wants from each is happiness and security.

A Tremendous Task

We as young Americans have a tremendous task before us. It is our job to solve the problem that we did not create. It is our job to make a better world for our children. Because the task is difficult we must begin now. We cannot wait until it is too late. As each of us advances in the field of education, science, culture, it is my hope that we will use this as our creed, as our formula of a "Young American."

"I pledge myself to be a true "Young American." I will seek opportunity to develop the talents that God has given me; my security will be spiritual not material. I reserve the right to be an uncommon man and I realize that my duty is to see that this non-conformity will bring out the true values of my character, integrity, hope, faith and love.

"My wish is that my life might never be obscured or dulled by having the state look after me. I want to be an individual who takes the calculated risk, to be a challenge instead of a guaranteed existence; I want to enjoy the thrill of fulfillment, not the state

calm of Utopia. With my convictions as my foundation, I will never trade my freedom for kindness or charity, nor my dignity for a helping hand. To do what is right and good and honorable in the eyes of man and in the eyes of God is every person's responsibility.

Responsibility is only a fourteen letter word. But its meaning is the core of human life. For we are created in God's image and our chief end on earth is to glorify and enjoy Him. Man's chief functions in the universe are to accept the challenge of learning about himself, to bear the burdens of his fellow man and to take on the responsibility of love, obedience, kindness and honesty.

The Goal

God sets our goal at perfection. It is up to us whether we shall move toward that goal or away from it. Yes, we can determine whether our destiny will be delightful or disastrous. Freedom or tyranny? Our responsibility is to choose one by thoughts, words and deeds.

To accept this responsibility as a blessing from God is what we consider to be the true meaning of freedom.

Editor's Note: The above Editorial, which won the 1962 Freedom Foundation Award for LaGrange High School, is from the student newspaper, The Clarion and was written by the 1961-62 Editor, Jim Newman.

"LEGISLATION, SOCIALIST STYLE"

GEORGE R. DILLINGER, M.D.



"KING-ANDERSON," otherwise H. R. 3920 or S. 880. Do you know these bills? Have you read them? The title is cited as "Hospital Insurance Act of 1963." Are you doing anything about it?

Law of the Land

If these bills become the law of the land, the Secretary of Health, Education and Welfare will be the "Czar" or "Dictator" of every hospital.

"Sec. 2 (a) The Congress hereby finds that (1) The heavy costs of hospital care and related health care are a grave threat to these individuals."

Is this statement true? Is it any greater threat to people over 65 than those under 65?

In 1960 the income per person age 65 and over, was \$1,240.00, those 64 or less \$1,300.00, after federal income and social security taxes are deducted.

The next statement in the bill "Sec. 2 (a) (2) most of them are not able to qualify for and to afford private insurance adequately protecting them against such costs."

Now, well over 50 per cent of people 65 and over pay for and have health insurance. About December 31, 1962, 9,550,000 people over 65 had health insurance, privately owned and paid for.

"Sec. 2 (a) (3) Many of them are accordingly forced to apply for private or public aid, accentuating the financial difficulties of hospitals and private or public welfare agencies and the burdens of the general revenues, and,"

There is universal agreement that those who cannot take care of themselves must receive help. King-Anderson would give help to everyone over 65, the banker, the lawyer, the merchant, the millionaire and the pauper. Is it even conceivable that the workers, the laboring man, should be taxed to pay

hospital costs for a whole segment of the population regardless of their financial standing and income?

"Sec. 2 (a) (4) It is in the interest of the general welfare for financial burdens resulting from hospital services and related services required by these individuals to be met primarily through social insurance."

Socialist Health Care

King-Anderson is not "insurance." It is a "tax" on the working people to pay for the cost of care of all people 65 and over, regardless of need.

King-Anderson substitutes federal government financing for Blue Cross-Blue Shield and health insurance financing. It would bring to an end the progress achieved by the prepayment plans and the health insurance companies in devising and selling the open market insurance policies tailored to meet the needs of solvent older people.

King-Anderson provides socialist health care, and transfers from the individual's families, the local community, and the state, to the federal government the responsibility for the purchase of health care for persons over 65 regardless of their ability to pay.

When the local community sends \$1.00 to Washington in taxes, less than \$.25 may come back.

We have here discussed one paragraph on page four of H. R. 3920.

What are you doing about King-Anderson?

A handwritten signature in dark ink, appearing to read "George R. Dillinger". The signature is fluid and cursive.

President, Medical Association of Georgia

1963-64 CALENDAR OF MEETINGS

State

September 20-21—Georgia Heart Association, Fifteenth Annual Meeting and Scientific Sessions, Biltmore Hotel, Atlanta.

September 30-October 4—"Five Days of Internal Medicine," sponsored by the Department of Medicine, Emory University School of Medicine, Atlanta.

October 17-19—Emory Postgraduate Seminar in Gynecology and Obstetrics offered by the Department of Gynecology and Obstetrics, Emory University School of Medicine, Atlanta.

May 3-6, 1964—110th Annual Session of the Medical Association of Georgia, Macon, Ga.

Regional

July 15-20—Duke Medical Postgraduate Course, Morehead-Biltmore Hotel, Morehead City, N. C.

July 17-19—Third Annual Dixie Postgraduate Assembly, Birmingham, Ala.

August 22-24—Sixteenth Annual Postgraduate Obstetric-Pediatric Seminar sponsored by Children's Bureau and the state health departments of Georgia, South Carolina, Mississippi, Alabama, and Florida, Riviera Beach Motel, Daytona Beach, Fla.

September 5-7—American Association of Obstetricians and Gynecologists, The Homestead, Hot Springs, Va.

October 1962-November 1963—Fourteen Postgraduate Courses offered by the University of Tennessee College of Medicine: September 16-20—"Anesthesiology for the General Practitioner;" October (dates to be determined) — "Endocrinology — Recognition and Treatment"; October 23-25 — "Obstetrics and Gynecology"; November 6-8 — "Preoperative and Postoperative Care of the Surgical Patient."

September 30-October 1—Tennessee Valley Medical Assembly, Read House, Chattanooga, Tenn.

October 6-9—Medical Society of Virginia, Roanoke Hotel, Roanoke, Va.

October 10-13—American Society of Maxillofacial Surgeons, Sheraton-Park Hotel, Washington, D. C.

October 13-18—International Congress of Plastic Surgery, Sheraton-Park Hotel, Washington, D. C.

October 14-18—Postgraduate course sponsored by the American College of Chest Physicians on Recent Advances in the Diagnosis and Treatment of Disease of the Heart and Lungs, Washington, D. C.

October 20-23—American College of Gastroenterology, Shoreham Hotel, Washington, D. C.

October 27—Association of Clinical Scientists, Statler-Hilton Hotel, Washington, D. C.

November 7-9—Conference on Obstetric, Gynecologic, and Neonatal Nursing sponsored by District Four, Washington, D. C.

November 8-9—Southern Society for Pediatric Research, St. Jude Hospital, Memphis, Tenn.

November 17-18—Twentieth Annual Meeting of The Southern Chapter of the American College of Chest Physicians, Monteleone Hotel, New Orleans, La.

November 18-21—Southern Medical Association, New Orleans, La.

National

July 15-19—Second International Conference on Congenital Malformations sponsored by the National Foundation-March of Dimes, Americana Hotel, New York City.

August 26—Annual Meeting of the American Academy of Physical Medicine and Rehabilitation, Sheraton-Dallas Hotel, Dallas, Tex.

September 15, 1963-June 15, 1964—Nine month tutorial program in Cardiology offered by the Institute for CardioPulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

September 16-28—Postgraduate course in Laryngology and Bronchoesophagology sponsored by the Department of Otolaryngology, University of Illinois College of Medicine.

October 5-11—Annual Otolaryngologic Assembly sponsored by the Department of Otolaryngology of the University of Illinois College of Medicine and the Illinois Eye and Ear Infirmary.

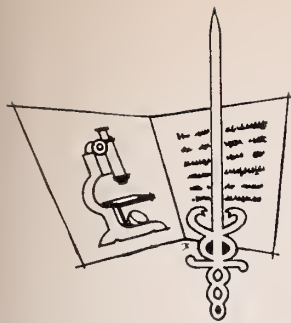
October 11-15, 1964—Eighth International Congress on Diseases of the Chest sponsored by the Council on International Affairs of the American College of Chest Physicians, Mexico City, Mex.

October 17-19—Clinical Neuropsychiatric Association, Sheraton-Lincoln Hotel, Houston, Tex.

October 21-22—American Cancer Society, Scientific Session, Conference on Unusual Forms and Aspects of Cancer in Man, Biltmore Hotel, New York City.

October 21-25—Postgraduate course sponsored by the American College of Physicians on Clinical Cardio-Pulmonary Physiology, Chicago, Ill.

November 11-15—Postgraduate course sponsored by the American College of Chest Physicians on Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, New York City.



MALIGNANT BONE TUMORS IN CHILDREN

F. James Funk, Jr., M.D., *Atlanta*

MALIGNANT BONE TUMORS in children are fortunately quite rare but despite this rarity, their unusually high level of malignancy has given them a widespread notoriety, and their malignant reputation has made them feared by physicians and laymen alike. Because of their reputation, many children are brought to the doctor with a variety of conditions which have caused their parents to fear that a malignancy may be present. Fortunately, many of the conditions often mistaken for malignant neoplasms are in a strict sense not even tumors at all. Most of the bony masses discovered by parents are either abnormal growth defects adjacent to the epiphyses or osteochondromata. Similarly, the type of bone lesion inadvertently picked up by X-ray is most apt to be either a simple bone cyst or a conversion defect wherein abnormal bone or cartilage is laid down by a misbehaving epiphysis. Whenever lesions are multiple, regardless of their nature, their benignity is almost always assured.

Complaint of Pain

Malignant bone tumors are usually seen with a presenting complaint of pain. Occasionally the initial problem is a mass or a pathological fracture. Rarely is the asymptomatic, inadvertently discovered lump or cyst a malignant tumor. Most malignant bone neoplasms in children fall into either the osteogenic group or the classification usually called Ewing's sarcoma.

Osteogenic sarcoma is a rare tumor usually seen in late childhood or adolescence. It is usually a neoplasm of the metaphysis of the long bone. Seventy-five per cent are found in the vicinity of the knee. The remainder are with rare exceptions

found in the upper femur, the lower tibia or the upper humerus. The pain, which is usually the first presenting complaint, is usually one of gradually increasing severity which makes rest difficult.

The presence of a mass is the second most common finding; when present, it usually consists of a smooth enlargement which often demonstrates increased circulation as evidenced by local heat and obvious and increased superficial vascularity. Muscle atrophy is commonly found, usually due to pain and consequent restriction of motion.

Pathology

Pathologically, the tumor typically arises in the metaphysis and tends to break out of its cortex, and spread into adjacent tissues. Microscopically, the picture is pleomorphic and shows both bone destruction and bone formation. Metastases, when they occur, tend to appear first in the lung fields, and may produce bone or cartilage. The X-ray picture usually shows active destruction of bone with surrounding areas of bone formation and subperiosteal calcification, which may show at the periphery a triangular area known as Codman's triangle.

Treatment should be preceded by careful study and biopsy. The results of treatment, though often poor, are not hopeless. Though these tumors are felt to be insensitive to X-ray therapy, it is this author's opinion that they are best treated by a thorough course of X-ray therapy locally, followed by amputation. Following X-ray therapy, the clinical picture usually improves. The pain, fever and mass subside and the patient looks and feels better. It is in this stage that amputation is most likely to be efficacious. Since the metastasis is usually blood

born, amputation should be well above the tumor but disarticulation, as such, is not mandatory.

Ewing's Sarcoma

Ewing's sarcoma is the other major malignancy of bone in childhood. Typically, it begins in the diaphysis and spreads thence into the metaphysis. Usually, the presenting symptom is pain, at first intermittent, gradually becoming severe and continuous.

This is usually followed by swelling and fairly and pronounced clinical manifestations consisting of fever, tenderness and often leukocytosis. These symptoms are so common that an initial diagnosis of osteomyelitis is often made.

Pathologically, the tumor tends to spread within the bone, breaking through the cortex only in late stages. Microscopically, the typical picture consists of uniform dark, round cells, closely packed together and often forming sheets. Though in the majority of the cases the primary tumor is found in the femur and tibia, other long bones, the ribs, vertebra, skull and small bones of the foot may be the primary site.

The X-ray findings typically show a destructive infiltrative process with overlying subperiosteal ossification, which has often been described as the "unionskin" appearance. The picture is variable but there is usually little doubt on the basis of the X-ray that a malignant tumor is present.

Outlook

In evaluating treatment, it must be realized that the outlook by any means is a very discouraging one.

Approved by the Professional Education Committee, Georgia Division, ACS.

X-ray therapy is usually the treatment of choice, but its main value lies in the amelioration of the symptoms. Typically, the tumor is locally radiosensitive, but tends to reappear at distant sites in almost all cases. Statistically, the best treatment is X-ray therapy followed by amputation in selected cases. It must be recognized that this tumor tends to spread in the medullary canal of the bones; thus, when amputation is to be performed, disarticulation is often the method of choice. This tendency for the tumor to extend beyond the limits visible by X-ray must also be taken into account when prescribing X-ray therapy.

Two other types of tumor are rarely seen and can be confused with Ewing's sarcoma. Neuroblastoma may arise as a malignant adrenal tumor, or may originate from the sympathetic nervous system. Lesions of the skull are usual, and symmetrical destructive areas in long bones are often seen.

Reticulum cell sarcoma is a neoplasm that closely resembles Ewing's tumor. Microscopically, it is usually seen in older individuals, though some childhood cases have been reported. Typically, the general condition of the patient is not affected and the final result is considerably more favorable than in true Ewing's sarcoma.

Malignant bone tumors in children are rare. The outlook, though discouraging, is not hopeless, and treatment, when begun early, is successful frequently enough to justify every effort. The best results have been obtained using X-ray therapy followed by surgery.

1938 Peachtree Road, N.W.

TOP MEDICAL PHOTOGRAPHS, ILLUSTRATIONS ANNOUNCED

A color photograph of an inflamed heart valve won the top prize in the fifth annual medical art competition conducted by the Student American Medical Association.

The prize winning photograph was one of a group of award winners displayed for the first time in a special exhibit at the 13th annual meeting of SAMA, at the Sherman House, May 1-5.

The heart valve photo—titled "Mitral Valvulitis, Acute Rheumatic Fever" was taken by Raphael K. Graves, M.D., resident in Pathology at Emory University School of Medicine, Atlanta.

Other top winners in the SAMA competition were: Photomicrography—"Aspergillus Fumigatus," by Kenneth A. Schneider, M.D., resident at Chicago Wesley Memorial Hospital; Medical Illustration—"Claw Hand Deformity," by David M. Kerr, a freshman student at the University of Texas Medical School, Galveston.

The medical art competition was open to entries from

medical student, interns and residents. This year, for the first time, a special category was established for entries from professional photographers and illustrators.

The award program is sponsored by Eaton Laboratories, division of the Norwich Pharmacal Company. Awards in the three categories (photography, photomicrography and illustration) are \$250, \$150 and \$50, plus trophies to the prize winners and honorable mentions. In the professional categories, the awards are \$100 plus trophies.

Following the SAMA convention, the Medical Art Salon will be shown at medical schools and hospitals throughout the nation. During the past year the traveling exhibits of the Third and Fourth Annual Salons have been enthusiastically received by more than 150 medical institutions. Requests for showing should be directed to the Executive Director, SAMA, 333 North Michigan Avenue, Chicago 1, Illinois.



PATENT DUCTUS ARTERIOSUS

John T. Yauger, M.D., *Atlanta*

PATENT DUCTUS ARTERIOSUS is a curable heart disease. It is also one of the three or four more common forms of congenital heart disease. Therefore, the importance of accurate diagnosis so that appropriate therapy may be instituted, is obvious. Furthermore, accurate diagnosis can be made in over 90 per cent of cases simply by a careful physical examination, augmented by standard X-ray and electrocardiographic evaluation.

Anatomy and Physiology

The ductus arteriosus is normally present and functioning in the fetus before birth. Functional closure is usually completed by two months of age, but patency may persist for six to 12 months. The important clinical implication here is that a functioning ductus, found during the first several months of life, should be considered abnormal only if adverse effects (such as cardiomegaly) can be demonstrated, and otherwise, should be considered merely as a normal variant.

The ductus, which is found two or three times more commonly in females than in males, forms a communication from the aorta, usually just distal to the left subclavian artery, to the pulmonary artery, close to its bifurcation. It is of variable size and shape, but generally 0.5 to 0.7 cms. in diameter and 0.7 to 1.0 cms. in length. The resultant blood flow in this shunt is generally from the aorta to the pulmonary artery. The subsequent changes in the heart are manifested as left ventricular enlargement (and to a lesser extent, left auricular enlargement) due to the increased amount of return blood flow to the left side; and as right ventricular enlargement due to increased resistance in the pulmonary artery. It may exist as an isolated anomaly, or as only one of multiple anomalies. In time, pulmonary hypertension may

develop, resulting in a reduction in the amount of blood flow through the ductus. Infrequently, this may be sufficient to cause a complete reversal in the direction of blood flow through the ductus.

Diagnosis

Physical Examination: The most important single physical finding is the typical continuous "machinery-like" heart murmur. Actually, this murmur is not absolutely continuous. There may be silence in the first portion of systole or in the latter portion of diastole. The murmur envelops (and may obscure) the second heart sound. It is harsh, rasping, and reaches a peak in the late systole and diminishes into diastole. It is heard maximally in the second left intercostal space near the sternal border. It may be transmitted to below the left clavicle. The systolic component may be widely referred and may be heard in the neck or over the back between the scapulae. The above location of greatest intensity is of utmost importance in diagnosis. A similar murmur heard maximally at some other area is most likely not due to a patent ductus. The "machinery" quality of the murmur depends on the differential pressures across the ductus. Therefore, the typical murmur is seldom heard before two years of age, there generally being a systolic murmur with or without a separate diastolic murmur at this time. However, specific diagnosis in this age group is important only if cardiomegaly is present, since elective surgery is not advisable during the first two years of life.

Cyanosis of the lower extremities and possibly of the left upper extremities may be present when there is reversal of blood flow. Use of systemic vasopressors may produce clearing of the cyanosis (by changing the direction of the shunt) just as may crying in a child.

Electrocardiogram: There is usually evidence of combined hypertrophy of the ventricles, and left axis deviation may or may not be present. Auricular fibrillation is quite unusual.

X-ray Examination: The most common finding is prominence of the pulmonary conus. Left ventricular enlargement is more common than combined left and right ventricular enlargement. There may be an enlarged left atrium. There is increased pulmonary vascularity, but true "hilar dance" is unusual. Calcification in the pulmonary artery may be seen after reversal of flow.

Differential Diagnosis

Because of the changing quality of the murmur with the passage of time, differential diagnosis usually involves other causes of a left to right shunt during infancy, and involves other causes of the continuous murmur during childhood and early adult life. Among the several causes of left to right shunt, the most important to be recalled would be differentiation from interatrial and interventricular septal defects.

Other causes of continuous murmur: 1. Venous hum: This murmur usually has a diastolic accentuation and is louder in the erect position (the murmur of patent ductus is loudest in the recumbent position). A venous hum changes with a change in head position, may be obliterated by pressure on the neck veins, and is frequently heard to the right of the sternum. 2. Ruptured aneurysm of sinus of Valsalva into the right heart or a coronary arteriovenous fistula produces continuous murmurs that are usually maximal over the sternum or to the right of the sternum. 3. Aortic septal defects. 4. Truncus arteriosus

and hemitruncus arteriosus. 5. Aortic regurgitation associated with ventricular septal defect (congenital) or with mitral regurgitation (rheumatic) produces murmurs which appear to be continuous but can generally be heard to be more of a "to and fro" murmur with separate systolic and diastolic components. 6. Pulmonic murmur associated with severe anemia.

Management

Successful obliteration of a patent ductus arteriosus was first reported by Gross and Hubbard in 1939. The surgical procedure of choice must be left to the operating surgeon, but both division (as preferred by Gross) and multiple ligation (as preferred by Blalock) gave satisfactory results. Operative mortality approximates two per cent.

As regards children, the ideal age range for surgery is between three and eight years. Surgery may be performed earlier if necessitated by appearance of complications. When first found after 30 years of age in an adult, and all forms of cardiac evaluation are otherwise normal, surgical correction becomes highly elective, the prevention of subsequent bacterial endocarditis being the major consideration.

Contraindications to Surgery

1. Other associated anomalies with a patent ductus serving a major compensatory function (such as pulmonary atresia).
2. Marked pulmonary hypertension (especially when associated with a small heart and right ventricular hypertrophy).
3. Reversed flow of shunt unless it can be determined that the pulmonary artery pressure falls and pulmonary circulation remains adequate during clamping of the patent ductus at surgery.

340 Boulevard, N.E.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

MEDICARE COVERAGE EXPANDED

According to instructions received by your Medicare Department from the Office for Dependents' Medical Care in Washington, D. C., the following changes are being made in coverage under the Medicare Program in Georgia:

1. On and after July 1, 1963, the accompanying dependents of active duty military personnel, who are members of the land, sea and air forces of North Atlantic Treaty Organization countries stationed or passing through this country, will be entitled to the same care under the Medicare Program as those dependents of members of the uniformed services. The standard Identification Form DD Form 1173 will be furnished to those dependents and all contractual pro-

visions, and criteria as to scope of care and eligibility will be the same as for dependents of members of our uniformed services.

2. Under the new Medicare contract effective as of March 1, 1963, the full fee allowed under the Medicare Schedule of Allowances for newborn care may be charged by all physicians regardless of whether or not they are the delivering physician.

3. Effective with the new Medicare Contract year which began on March 1, 1963, your Medicare Department will be making payments to the physicians of Georgia for services rendered under the Medicare Program one time per month.



"ARKANSAS CHIROPRACTORS' LICENSES REVOKED"

John L. Moore, Jr., *Atlanta*

IN A CASE decided this year in Arkansas entitled *Kuhl v. Arkansas State Board of Chiropractic Examiners*, the licenses of two chiropractors to practice chiropractic in Arkansas were revoked. The reason for the revocation was the illegal practice of medicine by the chiropractors. The revocations have been affirmed by the Supreme Court of Arkansas.

The evidence showed that the chiropractors held themselves out as giving the following treatment:

- Adjustments
- Vitamins or Supplements
- Plasmatic Therapy
- Traction
- Diathermy
- Muscle Stimulation
- Ultrasonic Therapy
- Infra-red Therapy
- Ultra-violet Therapy
- Ear Irrigation
- X-ray and Fluoroscopy
- Endo or Electrocardiograms
- Special Interpretations
- Laboratory Examinations
- Physical Examinations
- Basal Metabolism
- Hydrotherapy
- Blood Count—Urine

The evidence also showed that the chiropractors held themselves out as being able to give medication for stomach worms and pin-worms and that they indicated their ability to diagnose many diseases including cancer, by urinalysis.

The Court construed the evidence to show that

the chiropractors did not limit their practice to chiropractic but also engaged in the practice of medicine as it is defined in the Arkansas Medical Practice Act. The Arkansas Medical Practice Act defines the practice of medicine as including "suggesting, recommending, prescribing or administering any form of treatment, operation, or healing for the intended palliation, relief, or cure of any physical or mental disease, ailment, injury, condition or defect of any person with the intention of receiving therefor, either directly or indirectly, any fee, gift, or compensation whatever."

The interesting point to note is that the licenses revoked were *chiropractic* and that the Board revoking them was the *State Board of Chiropractic Examiners*. In other words, the chiropractic group in Arkansas was policing its own members.

It is also interesting to note that in Georgia, where the definition of the practice of medicine is exactly the same as in Arkansas, this result would not be possible under the present statutory framework.

Limited Scope

In Georgia the scope of practice of chiropractors is specifically limited by statute to the right to adjust patients according to specific chiropractic methods. The statute specifically says that "chiropractors shall not prescribe or administer medicine to patients, perform surgery, nor practice obstetrics or osteopathy."

However, the grounds upon which the State Board of Chiropractic Examiners in Georgia may revoke a chiropractor's license to practice chiropractic in Georgia do not include the ground of the extension of the practice by the chiropractor to the practice

of medicine. Therefore, the Georgia Board of Chiropractic Examiners could not revoke the chiropractic license of a chiropractor guilty of holding himself out as giving treatments listed above in the Arkansas case.

Powerless Board

Interestingly enough, in Georgia, the State Board of Medical Examiners would also be powerless. In 1957, the General Assembly passed a statute giving the State Board of Medical Examiners in Georgia the right to apply to the Superior Court for an injunction against any person illegally practicing medicine. However, the final clause of that statute contains these words:

“Provided, that no injunction or restraining order, as provided herein, shall be issued against any person licensed by any Examining Board created under the laws of Georgia, other than the Medical Examining Board.”

Accordingly, the Arkansas chiropractors' conduct

in Georgia would go completely uncontested by either the State Board of Medical Examiners or the State Board of Chiropractic Examiners. The only remedy which appears on Georgia statute books would be the criminal provision making it a misdemeanor for any person to practice medicine without complying with the provisions of the Georgia Medical Practice Act. Certainly, this criminal provision might be effective in some instances. However, in the policing of professions it has been found in many states that the use of criminal sanctions is a poor method because it leaves to the jury only a broad choice—leaving the person free to practice or denying him the right to his practice and putting him in jail. Consequently, most states which have effectively policed their professions do so on the basis of the sanctions imposed by the particular licensing board composed of members of the profession itself who do understand the limit of a profession and the seriousness of a member's transcending those limits.

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Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.

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ACTION FOR MENTAL HEALTH

IN 1955 the American Medical Association and the American Psychiatric Association conducted a series of meetings to determine the current needs in the field of mental illness and health. In turn, this led to a grant by Congress to be administered by the National Institute of Mental Health and the formation of the Joint Commission on Mental Illness and Health, "to analyze and evaluate the needs and resources of the mentally ill people of America and make recommendations for the national mental health program."

In March 1961, after five years of intensive study, the Joint Commission on Mental Illness and Health presented a 100,000 word report to Congress, the Governors and the Legislatures of the United States, and it is published under the title "Action for Mental Health."* This comprehensive report has become the real foundation and impetus for our current mental health program as presented by the first National Congress on Mental Illness and Health, which was sponsored by the American Medical Association, as well as President Kennedy's recent message to Congress on Mental Illness and Retardation, and the bills now before the House of Representatives to provide initial federal assistance.

Therefore, it seems appropriate at this time to publish for the benefit of all physicians of Georgia the following recommendations for implementation made by a Committee of the American Psychiatric Association as a guide to all states for an effective, on-going program of mental health.

American Psychiatric Association's Report on Implementation

I

The Position Statement adopted by the Council of the American Psychiatric Association on the final report of the Joint Commission on Mental Illness and Health on January 15, 1962, provides an acceptable general statement on the goals and principles which should serve as guides to action for helping the states of this nation to elevate their pro-

grams for treatment of the mentally ill and the preservation of mental health to a satisfactory level of operation.

It is important to recognize that the Position Statement differentiates between the principles and actions which are essential to effecting improvement of mental health services and those in which some latitude of interpretation of recommendations and of alternative actions are allowable. These distinctions appear to be sufficiently clear in the statement. There may be many optional courses of procedure suitable to local conditions and preferential predispositions, but effective action for improvement is dependent on firm commitment to designed programs to reach the following goals:

(1) The community centering of mental health services by establishment of new facilities when possible and by progressive modification of existing facilities to serve this end.

(2) Provisions of an adequate number of adequately trained staff to provide the quantity and quality of services required by the number of patients served.

(3) The size of the mental hospitals should be such that the staffs can function effectively in treatment management and that administrative problems do not overshadow those of treatment. This means that new hospitals should be smaller, not subject to undue expansion, and existing hospitals should either be reduced in size or divided into smaller units of full range treatment services.

(4) Hospitals should be located conveniently to the community from which their patients are drawn.

(5) While the Joint Commission did not specifically name and include every type of mental illness and disorder in its report, recognition of the comprehensive range of the conditions for which treatment services are required was implicit in the report. The facilities and staffs to supply this range of services should be available and also effectively coordinated in administration.

(6) There is a public obligation to meet the costs for providing adequate treatment for the mentally ill

* *Action for Mental Health*, Basic Books, Inc., 59 Fourth Avenue, New York 3, N. Y.

MENTAL HEALTH PAGE / Continued

when public care is required. There are several possible sources for meeting the public share of such cost—local, state and federal. The amount to be contributed from each source must vary to correspond with the differing conditions that exist in different areas. Treatment under private auspices, and private payments for care received in public institutions, when there is ability to make such payments, must continue. These are marks of the economy of a free society.

(7) Research is necessary to increase knowledge of the causes and means of treatment of mental illness. Training for people who will engage in the care

of the mentally ill is essential for rendering good treatment services of all kinds. A due portion of funds should be allotted for providing adequate research and training facilities and the staffs to conduct these activities.

II

The American Psychiatric Association is in a position to help implement and promote the program for increasing services for the mentally ill in the several states of this Nation through its members and District Branches, and through its relationships with other professional and lay organizations active in the mental health fields, notably the American Medical Association and the National Association for Mental Health.

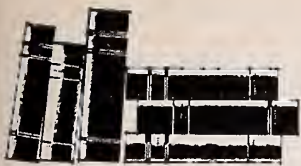
Prepared at the request of the Sub-committee on Mental Health of the Medical Association of Georgia.

How well are we telling our story?

PUBLIC HEARINGS on the KING-ANDERSON BILL have been tentatively set by the House Ways and Means Committee to begin on July 22nd.

Stars on the accompanying map indicate last month's effort by Georgia physicians to alert the public to the dangers inherent in this legislation.





PHYSICIAN'S BOOKSHELF

BOOKS RECEIVED

Landsteiner, Carl, M.D., **THE SPECIFICITY OF SEROLOGICAL REACTIONS**, Revised Edition, Dover Publications, Inc., New York, 1962, 330 pp.

Wilson, John Rowan, **MARGIN OF SAFETY**, Doubleday & Co., New York, 1963, 258 pp., \$4.95.

McLeave, **THE RISK TAKERS**, Holt, Rhinehart and Winston, Inc., New York, 1963, 208 pp., \$4.50.

Tauber, Robert, M.D., **KEYS TO SUCCESSFUL SURGERY**, Frederick Ungar Publishing Co., New York, 1963, 547 pp., \$15.00.

Bockus, Henry L., M.D. **GASTROENTEROLOGY, Volume 1. Examination of the Patient—the Esophagus and the Stomach. Second Edition**, W. B. Saunders Company, 1963.

THE FIRST EDITION of this book (one of three volumes) in 1944 by Dr. Henry L. Bockus was the first textbook in the field of gastroenterology, a distinction still held by this second edition of Volume 1. The other two volumes of this edition are to appear later.

This book, edited this time by Dr. Bockus, follows the same general outline as did its predecessor. The format, however, has been changed to two columns per page. The contents are contributed by members of the staff of the University of Pennsylvania Graduate School of Medicine and the School of Medicine. As so many changes in this relatively new field of medicine in the last 20 years have occurred, this book represents in reality a rewriting rather than a mere revision. Many entirely new subjects and chapters have been added. All this has been necessary due to the advances in endoscopy, cytology and biochemistry, especially as they pertain to diagnosis and therapy.

The book is primarily a textbook. Initially it is concerned with an orderly and detailed account of the proper examination of the patient, especially that patient with gastroenterological complaints. All the usual complaints, such as bad breath, nausea, etc., plus much attention to pain pathways are well outlined. This part of the volume would be attractive to any student. The rest of the book is concerned with the affections of the esophagus and stomach. Each chapter begins with its outline, which is most helpful. Many old, but excellent, and some new illustrations are present. Most chapters have summaries and all have adequate references, particularly references for any data not necessarily or thoroughly discussed.

The book is easy to read despite different "styles" and authors, something probably due to Dr. Bockus' editing. The data relative to the esophagus, particularly that referable to achalasia, is quite clearly done and is easy to follow. Much has been added on exfoliative cytology, both from the esophagus and from the stomach. The subject of dumping is quite detailed and contains a complete discussion of its many facets. The subject of tumors of the esophagus and stomach, gastritis, and most of the data on surgical care is essentially unchanged.

Certainly, this is a much needed edition of a much used book in a rapidly growing field of medicine. Many

of us appreciate the work of Dr. Bockus and his colleagues.

J. H. Hilsman

Forster, Francis M., B.S., M.D., **SYNOPSIS OF NEUROLOGY**, The C. V. Mosby Company, St. Louis, 223 pp., \$6.75.

THE WRITING OF A SYNOPSIS of a subject as broad as the field of neurology is probably as difficult a literary endeavor as one might set for himself. Dr. Francis Forster, Professor of Neurology at the University of Wisconsin, has accomplished this task very admirably with the 223 page text entitled *Synopsis of Neurology*.

It is designed primarily for medical students, family physicians, and physicians outside the field of neurology. It is divided into two sections, the first concerned with the neurological examination which is considered to be very good, and the second with the various neurological entities. The latter section has the usual handicap which is inherent in such a synopsis; that is, abbreviated, rather superficial statements which probably require a more extensive consideration before being truly useful to a medical student or physician. Eponyms and minutiae are very commendably kept to a minimum.

The references included at the end of each chapter are notably sparse in respect to some of the classic British texts of clinical neurology and also in respect to some of the classic and more recent neurosurgical contributions.

In general, the book is well organized, interestingly written, and easily readable.

Ellis Keener, M.D.

McGreggor, Ian A., **FUNDAMENTALS OF PLASTIC SURGERY AND THEIR SURGICAL APPLICATIONS**, 277 pp.

IN THIS BOOK of 277 pages, the author states that its purpose is to fill the gap between advanced books on Plastic Surgery, which often overlook the fundamental details, and the Plastic Surgery sections in books on General Surgery which do not give many practical details of technique. In this sense the author has admirably served his purpose. The usual format is followed in which principles of general wound care are discussed followed by an excellent chapter on the Z-Plasty. Next comes a section on skin grafts and detailed techniques for the use of both free skin grafts and pedicle flaps. This concludes the first portion of the book covering general principals and is followed by chapters on the applications of these principal problems in General Surgery, Orthopedic Surgery, Eyelid Surgery, and an excellent section on Hand Surgery. The Author concludes with a chapter on the management of maxillo-facial injuries which is an addition to the first edition published two years previously.

This book is chock full of little tips and points of technique that should be well known to the trained reconstructive surgeon, but that I have not seen compiled before in a single small volume.

I feel that this book should find its greatest usefulness to the physician in training or as a general re-

PHYSICIAN'S BOOKSHELF / Continued

ference, but should not be used as a complete do-it-yourself manual by someone who is not adequately trained in these techniques.

C. G. Magnan, Jr., M.D.

Lynch, M. J.; Raphael, S. S.; Mellor, L. D.; Spare, Hills, P.; Inwood, M. J., **MEDICAL LABORATORY TECHNOLOGY**, W. B. Saunders Co., Philadelphia, 1963, 735 pp.

THIS BOOK, is an excellent attempt to present concise, up-to-date information in the field of Medical Technology. It can be hoped that the senior author will soon bring forth a new edition which will cull much of the chaff from the very valuable wheat. Clearly written, well-illustrated, finely bound, the book is frustrating in the style of print, poor corrections of subject matter, and span of material it attempts to cover.

There is a valuable spark of readability in this work. The indexing is superior; the work is accurate, albeit not carried to the same depth from one subject to another.

I would recommend this book to those who would teach technologists, not technicians. For the latter, more illustrations will be needed; more information on pitfalls and common sources of error.

I like the book, have found it quite useful, but can only hope for serious re-editing in the near future.

Joseph F. Kafka, M.D.

Members of the Staff of the Lahey Clinic, Boston, Mass., **SURGICAL PRACTICE OF THE LAHEY CLINIC**, W. B. Saunders Company, Philadelphia, 1962, 872 pp., \$17.00.

THIS IS THE third volume bearing this title. The first was published in 1941 and the second in 1951. It is not a textbook nor is it a "yearbook." It is rather a

showcase for exhibition of some of the wares of a pre-eminent medical group.

The subject matter is diversified, being divided into 12 categories ranging from "Brain and Spinal Cord" to "Bones and Joints" and also one labelled "Miscellaneous".

About half the volume is devoted to intra-abdominal conditions involving the intestinal tract, liver, pancreas, spleen and adrenals. Although no dramatically new concepts are introduced, the topics discussed have been well chosen and well written without being hackneyed or verbose. Each article, in addition to summarizing current concepts of management and treatment, presents lucidly and with simplicity the extensive experience of the Lahey Clinic staff.

I think there is good reason for including such diverse topics as "Techniques of Stereotactic Surgery" and "Management of Bile Duct Strictures" in the same volume. The reader may not find the first piece of direct value, but he can at least learn something about this highly specialized procedure in a brief essay not readily available elsewhere.

I would give top honors to the eight topics included in the section on "Bones and Joints", probably because of personal interest in this field.

I found fault with few things. In the article on "Ulcerative Colitis," the statement is made that "with normal ileostomy function, replacement of fluids and electrolytes rarely becomes a problem." In my own limited experience I have found fluid and electrolyte replacement not quite so simple. In the "Miscellaneous" section the article "A Cardiac Monitor Pacemaker: Use During and After Anesthesia," was confusing as applied to cardiac arrest. There was no mention of external cardiac massage as an alternative method of management.

I would highly recommend this book to anyone who does surgery.

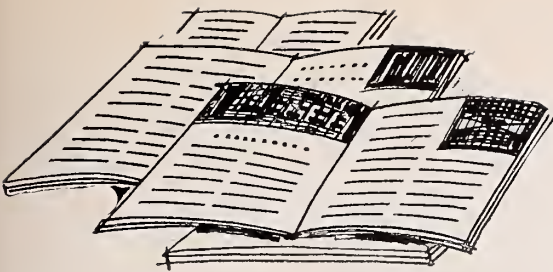
Charles M. Henry, M.D.

NEW MEDICAL PRACTICE UNITS 'PLANNING GUIDE' OFFERED BY AMA, SEARS-ROEBUCK

The American Medical Association, in conjunction with the Sears-Roebuck Foundation, has recently published a new planning guide for establishing medical practice units. Done on heavy vellum paper and consisting of 82 pages, the guide, of which there is only a limited supply, is available to any doctor. The guide contains suggestions on location, hospital and patient accessibility, size, property costs, shape and placement of building, climate, parking, landscaping, remodeling, and a number of other important ideas regarding a medical office. Floor plans for each room needed in an office are given in black and white scale drawings and several suggested plans for two and three man offices are shown. Examples of "do-it-yourself" possibilities for medical practice facilities are illustrated along with lists of equipment and their prices. Doctors interested in obtaining the new planning guide should write to the Medical Association of Georgia Headquarters Office, 938 Peachtree St., N.E., Atlanta 9, Georgia.

GEORGIA DERMATOLOGISTS HOLD MEETING IN BRUNSWICK

The Georgia Society of Dermatologists met Sunday morning, May 5, 1963, at the offices of Dr. Marvin Engel, Brunswick, to view, examine and discuss a group of unusual and interesting cases which he collected for the members and guests. At the business meeting which followed, Dr. Richard B. Ewing, Macon, was elected chairman to succeed Dr. Engel and Dr. R. M. Reifler, Macon, was re-elected Secretary-Treasurer. Out of state guests: Dr. Lamar S. Osment, Birmingham, and Dr. J. Graham Smith, Jr., Durham, were entertained Saturday night at a cocktail party and steaks to the rhythm and music of a washboard band at Benny's Red Barn and on Monday evening to a barbecue at the South Picnic Area. At the MAG Joint Section Meetings Dr. Osment gave a paper on "Lupus Erythematosus" Sunday afternoon, and "Tropical Treatment for Skin Diseases" Tuesday morning, while Dr. Smith spoke on "Aging Skin" Monday morning and "Management of Common Dermatological Problems in the Southern United States" Tuesday morning.



CURRENT CLINICAL CONCEPTS

What's New in Surgery

IT IS BECOMING INCREASINGLY important that all physicians keep pace with the ever increasing contributions that appear each day on the medical horizon. This series of manuscripts, available upon request to the editor should be in the library of every American physician interested in surgery and related specialties. The newest in cardiovascular surgery as well as general surgery, the various specialties including urology, neurology, nutrition, obstetrics, gynecology, orthopedic surgery, plastic surgery and the myriad new aspects of anesthesia are well worth reading.

Lewis F. John. *S.G.&O.*, 1963, 116:131.

A Note for the Curriculum Committee

"IT IS ALL VERY FINE to insist that the eye cannot be understood without a knowledge of optics, nor the circulation without hydraulics, nor the bones and the muscles without mechanics: that metaphysics may have their use in leading us through the intricate functions of the nervous system, and the mysterious connection of mind and matter. It is the truth; and it is the truth also that the whole circle of science is required to comprehend a single particle of matter: but the most solemn truth of all is, *that the life of man is threescore years and ten.*"

Bean, W. B.—"Aphorisms from Latham"—*Prairie Press*, 1962.

"Swiss Cheese" Nuclei in Infectious Mononucleosis Lymphocytes

INCUBATION AT ROOM TEMPERATURE for three hours of anticoagulated or defibrinated blood from patients with infectious mononucleosis or febrile post-cardiotomy lymphocytic splenomegaly leads to the production of 15 to 230 "Swiss Cheese" nuclei per 1,000 lymphocytes. These nuclei are not found in direct smears of capillary blood of these patients and have not been found in normal blood or leukemic blood in three hours incubation.

Ghaemi, A., and Seaman, A. J.: "Swiss Cheese" Nuclei: An Incubation Deduced Lesion of Infectious Mononucleosis Lymphocytes. *Amer. J. Clin. Path.* 39:492, 1963.

Prenatal Vaccinia

PRIMARY MATERNAL VACCINATION against smallpox during pregnancy, can result in fetal vaccinia. In the majority of cases reported, vaccination for the first time was done in the first trimester and the affected fetus was stillborn a few weeks later. But it is reported that primary vaccination of the mother

even in the second trimester can harm the fetus and should be avoided unless the chances of the mother contracting smallpox are very high.

Naidoo, P., and Hirsch, H.: Prenatal Vaccinia. *Lancet*. 1:196, 1963.

Trivial Wounds of Eyelids With Intracranial Damage

THE BONE OF THE ROOF of the orbit is thin and easily fractured. In a child the lack of development of the supraciliary ridges makes it particularly vulnerable to any wound inflicted in an upward direction. All penetrating wounds in the region of the orbit should call for immediate X-ray examination, with special reference to the roof of the orbit.

Guthkelch, A. N.: Apparently Trivial Wounds of Eyelids with Intracranial Damage. *Brit. M. J.* 2:842, 1960.

Plastic Induration of the Penis: Peyronie's Disease

CURVATURE OF THE PENIS due to fibrosis of the intercavernous septum is not an uncommon crippling disease of the male genitalia. Etiology is not well established, hence, therapy is infrequently satisfactory. However, the injection of appropriate steroids deep into the fibrous penile plaque is said to produce results comparable to or better than Vitamin E, irradiation or other forms of treatment.

Chesney, J.: *British Journal of Urology*.

Treatment of Tumors of the Testis

TUMOR OF THE TESTIS occurs more frequently in the undescended testis even after orchidopexy. Simple orchiectomy combined with radiotherapy and preferably supravoltage therapy achieves as good crude five-year survival rates as orchiectomy and radiotherapy combined with lymphadenectomy.

Hope-Stone, M. B. and Blandy, John P. *British Medical Journal*, 948: April 13, 1963.

The Collection and Assessment of Mid-stream Urine Samples in the Diagnosis of Urinary Tract Infection in Women

EVIDENCE IS AVAILABLE to prove that mid-stream urine specimens are satisfactory for diagnostic purposes in female patients. Quantitative bacterial counts offer a better evaluation of urinary infection than simple cultures. Women can be instructed to collect or to produce mid-stream specimens that compare favorably with catheterized specimens and obviate the possibility of the introduction of a urinary tract infection into the female bladder.

Dawborn, J. K., and Plunkett, P. J. *The Medical Journal of Australia*, 540: April 13, 1963.

THE ASSOCIATION



DEATHS

CORNELIUS FULMER HOLTON, 73, a Savannah physician for more than 43 years and a former city alderman, died April 30, 1963, at Central of Georgia Hospital after a long illness.

A native of Lakeland, Florida, he spent his youth in Cordele and was graduated from the Atlanta College of Physicians and Surgeons in 1913.

He was chief surgeon of the Central of Georgia Hospital from 1945 until his retirement from that post in 1959. He had continued in private practice since that time.

Dr. Holton was a member of the board of trustees of the Georgia Infirmary and a member of the board of trustees of the Vocational Rehabilitation Center. He was a past president of the Medical Association of Georgia, past president of the Georgia Medical Society, a past president and founder of the Georgia Industrial Surgeons Association, first president and founder of the Georgia Chapter of the Southeastern Surgical Congress, a member of the American Association of Industrial Physicians and a former vice president of the American Association of Railway Surgeons.

He was a past president of the Savannah Golf Club, a member of the Savannah Rotary Club, the Hibernian Society, the Oglethorpe Club, Alee Temple of the Shrine and was a past commander of the Military Order of World Wars.

Surviving are his wife, Mrs. Mary Gray Holton; a son, Robert Fulmer Holton of Athens; a daughter, Mrs. Thomas R. Freeman; and several grandchildren.

ROY L. JOHNSON, 54, of Douglas died at Emory University Hospital, Atlanta, May 14, 1963. A native of Atlanta, he graduated from the University of Alabama, and received his medical degree from the University of Chicago. Dr. Johnson served an internship at Los Angeles County Hospital and did further study at the University of North Carolina. He was a member of the Douglas Presbyterian Church and had served as President of the Coffee County Chamber of Commerce.

In addition to his wife, Dr. Johnson is survived by three daughters: Mrs. William E. Harris, Melbourne, Fla.; Mrs. Willie Jim Kirkland, Tampa, Fla.; and Clare Johnson, an eighth grade student at Douglas Junior High; two brothers: Drew Johnson, Miami, Fla.; Harris Judge Johnson, Atlanta; one sister, Mrs. Ruth Elizabeth Wilson, Atlanta; and four grandchildren.

J. A. LEAPHART, 53, died May 1, 1963, at his home in Jesup after a long illness. A native of Augusta, Dr. Leaphart came to Jesup in 1934, where he served two terms as mayor. He operated the Leaphart Hospital until the Wayne Memorial Hospital was constructed.

Before coming to Jesup, Dr. Leaphart interned in the Atlantic Coast Line Railroad Hospital, Waycross. He served on the county welfare board, the Wayne County Board of Health, and as a district officer in the American Medical Association. He was a member of the Jesup First Methodist Church, the Georgia Medical

Society, the American College of Chest Physicians, the Wayne County Medical Association, and he was a Mason, Shriner, Elk and Kiwanian.

Survivors are his wife, Mrs. Betty Gibbs Leaphart, Jesup; two daughters, Miss Florence Leaphart, of Atlanta; Miss Patricia Leaphart, of Jesup; two sons, J. Alvin Leaphart, Jr., of Atlanta; Ben Leaphart, Jesup, and his stepmother, Mrs. Lula Leaphart, of Augusta.

ROBERT C. MAJOR, 55, of Ft. Sanders, New Mexico, formerly of Augusta, died May 13, 1963, in New Mexico.

A native of Latta, South Carolina, Dr. Major practiced thoracic surgery in Augusta for a number of years and was head of the Department of Thoracic Surgery at the Medical College of Georgia.

He moved with his family to Ft. Sanders, February 1, where he was on the staff of the Ft. Sanders State Hospital. During his residency in Augusta he also served as consultant for Battey State Hospital in Rome.

A graduate of Johns Hopkins Medical School, Dr. Major later served as an instructor in surgery at Louisiana State University, University of Michigan, and Emory University.

He was a member of the American College of Surgeons, American Association for Thoracic Surgery, Southeastern Surgical Congress, Trudeau Society, Richmond County Medical Society.

He is survived by his widow, Mrs. Norma Lutgen Major, three daughters, Mrs. Kim D. Ledford, of North Augusta, Mrs. Dick Park, Philadelphia, Pa., and Miss Elizabeth Major of Oberlin College, Oberlin, Ohio; and his mother, Mrs. E. C. Major of Latta.

SOCIETIES

BIBB COUNTY MEDICAL SOCIETY held its annual meeting in Macon, May 14, to discuss the Medical Aspects of Little League Sports.

A report on the physical fitness program and the state meeting of society officers was given at the WARE COUNTY MEDICAL SOCIETY meeting held May 2 in Waycross.

PERSONALS

First District

No news submitted

Second District

No news submitted

Third District

JAMES E. OUTLAR has recently announced that T. EARL DuPREE has joined him in the general practice of medicine in Warner Robins.

Collaborating on an article in the May issue of *Medical Times* were LEONARD T. MAHOLICK and DAVID S. SHAPIRO of Columbus.

Two Columbus psychiatrists were installed as officers of the Georgia Psychiatric Association May 5, at a

tri-annual meeting at Jekyll Island. CHARLES R. SMITH assumed the duties of President and LUTHER J. SMITH was installed as secretary.

Fourth District

No news submitted

Fifth District

Recently designated as Associates of the American College of Physicians March 31, were ARTHUR M. PRUCE, CHARLES B. UPSHAW, JR., and ROY A. WIGGINS, JR., Atlanta.

Guest speaker at the annual meeting of the Arkansas State Medical Society in Little Rock, April 22-25 was TED F. LEIGH, Atlanta.

BRUCE LOGUE, Atlanta, has recently made several talks in surrounding states. He spoke to the Medical Association of South Carolina at their meeting at Myrtle Beach, S.C., on "Differential Diagnosis of Chest Pain;" and while in North Carolina addressed the Heart Association of Charlotte and Mecklenberg County in Charlotte on "Advances During the Last Decade in Cardiology," and spoke to the N. C. Heart Association in Durham, N.C., on "The Diagnosis and Management of Congestive Heart Failure."

JAMES A. JOHNSON, JR. and ALFRED MESSER recently presented papers at the American Psychiatrists Association meeting in St. Louis, May 6-10. Dr. Messer spoke on, "Ethnocultural Identity and Mental Health," and Dr. Johnson's topic was, "Comprehensive Group Programs."

Atlanta psychiatrist, WINSTON E. BURDINE, was one of the lecturers at the Legal-Medical Seminar held May 10-11 at the State University of Iowa in Iowa City. His topic was, "Personal Injuries and Psychiatry."

F. WILLIAM DOWDA, Atlanta, has recently been elected President of the Emory University Medical Alumni Association. Other new officers elected include JAMES V. ROGERS, JR., Decatur, Vice President; LUTHER C. ROLLINS, JR., Atlanta, Secretary-Treasurer; and J. D. MARTIN, JR., Atlanta, Trustee. R. Hugh Wood, Atlanta, Professor of Medicine and former Dean of the medical school was presented with the Medical Alumni Association's Award of Honor in appreciation of his contributions to Emory University and the school of medicine.

Sixth District

Recently selected as President-Elect of the Georgia

Psychiatric Association at the May 5 tri-annual meeting held at Jekyll Island was THOMAS M. HALL, II, of Macon.

WADDELL BARNES, Macon, was recently named President-Elect of the Georgia Society of Internal Medicine at the recent meeting held at Jekyll Island in connection with the 109th Annual Session of the Medical Association of Georgia.

Named recently as President-Elect of both the Alumni Society of the Medical College of Georgia and the Georgia Society of Obstetrics and Gynecology was JULE C. NEAL, JR. of Macon.

Seventh District

Bremen physician, CHARLES H. ALLEN, was among a group of 50 Georgians who left Atlanta May 17 for a three week tour of Europe and the Soviet Union. The tour was for the purpose of studying farming methods and exchanging agricultural ideas.

Named as Associates of the American College of Physicians on March 31 were LUTHER G. FORTSON, JR., and ALFRED H. RANDALL, JR., of Marietta.

Eighth District

Speaking on Socialized Medicine at the May 7 meeting of the Blackshear Rotary Club was J. DUNCAN FARRIS of Waycross.

Ninth District

H. H. McNEELY, Toccoa, was in New York City April 29-May 3 to attend a medical meeting of abdominal surgeons.

Lyons native BEN CLIFTON of Atlanta has recently announced his retirement from the practice of medicine.

Tenth District

Elected as Treasurer of the Georgia Psychiatric Association at the recent meeting held at Jekyll Island was JULIUS T. JOHNSON of Augusta.

Augusta psychiatrist and co-author of the book, *The Three Faces of Eve*, CORBETT H. THIGPEN delivered a talk, "Faith as a Factor in Psychotherapy," at the 13th Annual Meeting of the Student American Medical Association held in Chicago in May.

Elected President of the Georgia Pediatrics Association at the recent Jekyll Island meeting was WILLIAM A. WILKES, Augusta.

MEDICAL ASSOCIATION OF GEORGIA COUNCIL MEETING

THE QUARTERLY MEETING of the Council of the Medical Association of Georgia was called to order at 6:10 P.M., May 4, 1963, at the Buccaneer Motel, Jekyll Island, by the Chairman George H. Alexander.

Members of Council attending were: Walker L. Curtis, College Park; Floyd Sanders, Decatur; A. W. Simpson, Jr., Washington; Thomas W. Goodwin, Augusta; George R. Dillinger, Thomasville; Charles E. Bohler, Brooklet; Lee H. Battle, Rome; Frank Wilson, Leslie; William Rawlings, Sandersville; Fred H. Simon-ton, Chickamauga; Walter Brown, Savannah; Paul Scoggins, Commerce; John S. Atwater, Atlanta; Harry Pinson, Augusta; John T. Mauldin, Atlanta; Virgil Williams, Griffin; F. G. Eldridge, Valdosta; J. C. McDaniel, Atlanta; George H. Alexander, Forsyth; J. W. Chambers, LaGrange; Luther H. Wolff, Colum-

bus; Joseph B. Mercer, Brunswick; J. Frank Walker, Atlanta; and C. R. Andrews, Canton. Mr. John Moore, MAG Attorney; Mr. Milton D. Krueger, Mr. James M. Moffett, Miss Thelma Franklin, and Mrs. Catherine Wooten, of the MAG Staff were also present.

Reading of Minutes

Mr. Milton Krueger reviewed the minutes of the March 23-24 Council meeting. A correction was made in these minutes to include Dr. and Mrs. Paul T. Scoggins, Commerce, as hosts at the March Council meeting. The minutes of the March 23 and April 15 Executive Committee meetings were also reviewed. On motion duly made and seconded it was voted to approve these minutes as read.

Treasurer's Report

Dr. Atwater gave the Treasurer's report. He stated that the Contingent Fund has been reduced to about \$350.00 and suggested that Council consider approving that \$5,000 be taken

THE ASSOCIATION / Continued

from savings and transferred to the Contingent Fund. On motion (Sanders-Bohler) it was voted to transfer the above amount as designated, and on further motion the Treasurer's report was approved as presented.

Annual Session Review

Mr. Krueger stated that Dr. Hydrick was ill and could not attend the Annual Session. On motion duly made and seconded it was voted to send him a telegram. Mr. Krueger reviewed the activities of the Annual Session.

Old Business

(1) Pension Plan for MAG Employees: Dr. McDaniel informed Council that he had investigated several plans and had decided that a plan submitted by the Fulton National Bank was best. He asked Council to consider approval of the plan in principle, with the details to be worked out, and on motion (Walker-Brown) it was so approved.

(2) Mental Health Subcommittee Recommendations: Dr. Mauldin stated that the recommendations made by Dr. Yochem had been approved by the MAG Mental Health Subcommittee and that the Subcommittee had incorporated these recommendations in their annual report, which would be studied by Reference Committee No. 5.

New Business

(1) Maternal and Infant Welfare Subcommittee Letter: Mr. Krueger read a letter from the Maternal and Infant Welfare Committee regarding support of two bills, H.R. 3386 and H.R. 3689, which are now being considered before the U.S. House of Representatives. On motion (Walker-Brown) it was voted that Council take no position on these two bills and refer this request to the National Legislation Subcommittee for report back to Council. Copies of these bills are to be obtained for study.

(2) Resolution of Commendation of State Board of Medical Examiners: Dr. Simpson read a resolution he had drawn up for Council consideration. This resolution is one of commendation to the Board of Medical Examiners for the dispatch and manner in which a licensure problem was handled by the Board. On motion (Simpson-Scoggins) it was voted to approve this resolution and to send a copy to each member of the Board of Medical Examiners.

(3) Advertisement in Georgia Press Association Publication: Mr. Krueger stated that the Georgia Press Association had asked MAG to advertise in their June issue. The cost of a full page ad is \$120.00. On motion (Brown-Bohler) it was voted that MAG take a full page ad. It was also suggested that the Chairman of the Public Service Board determine the information to be used in the ad.

(4) GaMPAC Breakfast: Mr. Moffett reminded Council to attend the breakfast on Tuesday, May 7, 7:30 A.M., Wanderer Motel.

(5) Chairman Alexander expressed appreciation for the privilege of serving as Chairman of Council for the past two years. He was given a rising vote of thanks.

(6) Dr. Simonton thanked Council for the privilege of serving as President-Elect, President, and Immediate Past President on Council, and he was given a rising vote of thanks.

(7) Date and site of June Council Meeting: June 8-9, 1963, Callaway Gardens. Drs. Chambers and Cowart invited Council to come a day early for the festivities at the Gardens, if possible.

There being no further business the meeting was adjourned at 7:25 P.M.

1963-64 ORGANIZATIONAL MEETING OF THE COUNCIL OF THE MEDICAL ASSOCIATION OF GEORGIA

THE 1963-64 ORGANIZATIONAL meeting of the Council of the Medical Association of Georgia was called to order by President George R. Dillinger, Thomasville, at 12:05 P.M., May 8, 1963, in the Aquarama Meeting Hall, Jekyll Island, Georgia.

Council members attending were: Walter Brown, Savannah; John T. Mauldin, Atlanta; C. R. Andrews, Canton; George H. Alexander, Forsyth; J. G. McDaniel, Atlanta; Frank Wilson, Leslie; J. Frank Walker, Atlanta; Paul T. Scoggins, Commerce; John Kirk Train, Savannah; Charles E. Bohler, Brooklet;

Thomas W. Goodwin, Augusta; Joseph B. Mercer, Brunswick; Virgil B. Williams, Griffin; Walker L. Curtis, College Park; Floyd Sanders, Decatur; C. T. Cowart, LaGrange; F. G. Eldridge, Valdosta; John S. Atwater, Atlanta; George R. Dillinger, Thomasville; and Addison W. Simpson, Washington. Staff members present were Mr. Milton Krueger, Mr. James Moffett and Mrs. Catherine Wooten.

Welcome to New Councilors

President Dillinger welcomed the new Councilors and Officers to the first organizational meeting of the MAG Council for 1963-64.

Nomination and Election of Council Chairman and Vice Chairman for 1963-64

On motion (Wilson-Alexander) Dr. Addison W. Simpson was elected Chairman of Council. On motion (Alexander-Bohler) Dr. Walter Brown was elected Vice Chairman of Council.

Chairman Simpson thanked Council for reelecting him to this position and proceeded with the business at hand.

Council Appointment of Editor of J MAG

On motion (Alexander-Mauldin) it was voted to reappoint Edgar Woody, Jr., Atlanta, as Editor of J MAG.

Council Appointment of Finance Committee

Dr. Virgil Williams, Griffin, was appointed Chairman of the Finance Committee, with C. R. Andrews, Canton, and Charles E. Bohler, Brooklet, as members.

Chairman Simpson then asked for a five minute recess of the Council meeting in order for the Executive Committee to meet.

Executive Committee of Council Organizational Meeting

President Dillinger, Chairman of the Executive Committee, called the Executive Committee to order at 12:10 P.M.

Members of the Executive Committee present were: George R. Dillinger, Thomasville; John T. Mauldin, Atlanta; Thomas W. Goodwin, Augusta; A. W. Simpson, Washington; J. G. McDaniel, Atlanta; Virgil B. Williams, Griffin; Walker L. Curtis, College Park; and John A. Atwater, Atlanta. Staff member present was Mrs. Catherine Wooten.

Appointment of Treasurer for 1963-64

By general agreement it was recommended that John S. Atwater, Atlanta, be reappointed Association Treasurer for 1963-64.

Selection of Executive Secretary for 1963-64

By general agreement it was recommended that Mr. Milton D. Krueger be reappointed Executive Secretary of the Medical Association of Georgia for 1963-64.

Georgia Hospital-Medical Council Appointment

On motion (Goodwin-Mauldin) it was voted to appoint Dr. George Alexander, Forsyth, to the Georgia Hospital-Medical Council.

Mental Health Subcommittee Appointment

On motion (Goodwin-Dillinger) it was voted to appoint Dr. E. E. Davis, Thomasville, as the Second District representative on the Mental Health Subcommittee.

Date and Site of June Executive Committee Meeting

By general agreement it was recommended that the Executive Committee meet at 9:00 A.M., on June 8, 1963, at Callaway Gardens, as Board and Committee appointments have to be made at this meeting.

There being no further business the Executive Committee meeting was adjourned at 12:15 P.M.

Reconvened Organizational Meeting of Council

Chairman Simpson called the reconvened organizational meeting of Council to order at 12:15 P.M.

Council Action on Executive Committee Recommendations

On motion duly made and seconded the previous action of the Executive Committee on the reappointment of John S. Atwater, Atlanta, as Treasurer for 1963-64; and the selection of the Executive Secretary, Mr. Milton D. Krueger, were approved.

New Business

(1) Date and Site of June Council Meeting: June 8-9, 1963, at Callaway Gardens.

There being no further business the meeting was adjourned at 12:25 P.M.

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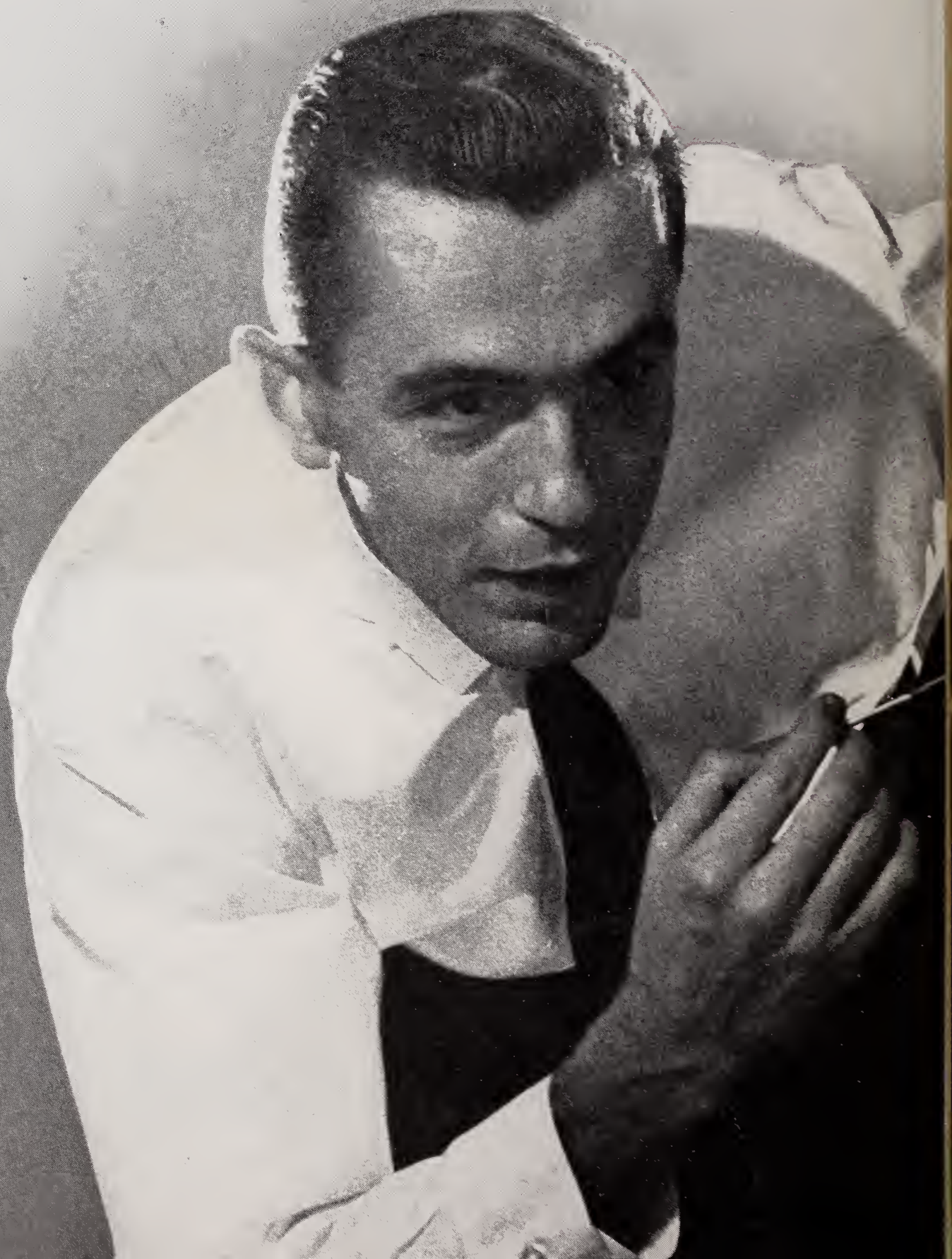
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Contents

Scientific Articles

CONTROL OF ABNORMAL PROSTATIC BLEEDING

Albert W. Biggs, M.D., and Marion Dugdale, M.D. 351

SERIOUS TOXICOLOGIC REACTION TO SOME COMMONLY USED DRUGS

D. Frank Mullins, M.D.; Zeb Burrell, M.D.; Hart Sylvester, M.D.;
and Norman Gardner, M.D. 354

AGING SKIN, THE CHANGES IN COVERED AND EXPOSED DERMIS

J. Graham Smith, Jr., M.D. 356

AMENORRHEA OF PITUITARY ORIGIN

William C. Shirley, M.D. 359

AN UNUSUAL COMPLICATION ASSOCIATED WITH OMPHALOCELE

James E. Anthony, Jr., M.D. and William G. Brawley, M.D. . . . 363

Editorials

THE ROLE OF THE THYMUS GLAND. 365

PSYCHOTHERAPY WITH THE FAMILY IN SCHIZOPHRENIA . . . 366

Features

How Well Are We Telling
Our Story? 358

President's Letter 369

Cancer Page 371

Heart Page 374

Mental Health Page 376

Abstracts 380

The Association

Deaths 381

Societies 381

Personals 381

Executive Committee of
Council Meeting, June 8 . 382

MAG Council Meeting, June 8. 383

Advertising Index 40A

Cover

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CONTROL OF ABNORMAL PROSTATIC BLEEDING

Albert W. Biggs, M.D., and Marion Dugdale, M.D., *Memphis, Tennessee*

Prevention is primary in the control of this problem.

THE CONTROL OF BLOOD LOSS during surgery has been attacked in many different ways. The success of surgical hemostasis has been one of the main factors in the lower operative mortality rates we now enjoy. In general, there has been a continual striving to improve operative techniques and instruments. We have also had unlimited blood replacement readily available to tide us over until we can mechanically control hemorrhage. The other avenues of investigation have been in the understanding of the clotting mechanism and the replacement of specific factors that may be lacking. When all else has failed, we have as many different agents to give as thoughts and veins will allow.

Prevention

The first step in the control of abnormal prostatic bleeding is its prevention. This is often possible by trying to obtain a history of previous bleeding difficulty, or of anticoagulation therapy. When a history of previous bleeding problems is obtained, then the patient should have his clotting mechanism studied so any specific difficulties may be controlled prior to surgery. The same is true when a history of anticoagulation therapy is obtained. Here, with withdrawal of the anticoagulants and starting vitamin K₁ therapy, these patients may have their clotting problem improved within 24 hours.

In cases where time does not permit a full hema-

tology workup, the history is the most helpful hemorrhagic study. In the borderline patient with a doubtful history, the bleeding and clotting time should be obtained.¹ The present trend is to substitute the more sensitive partial thromboplastin time for the clotting time. Though these tests may not give specific information as to the level of the defect, they will confirm or disprove the presence of abnormal bleeding.

Distinction

The second step in the control of abnormal bleeding, especially postoperatively, is to distinguish that due to technical errors or omissions from that due to derangements in the clotting mechanism. In prostatic surgery this is often very difficult to do because of the age of the patient, the integrity of the vessels, the nature of the procedure, and the constant flow of urokinase and possibly bacterial kinases over the operative area.² These kinases are potent proteolytic enzymes and activators of the fibrinolytic system. An outline of the various major factors in hemostasis may be a help in delineating the cause of hemorrhage and the selection of therapy.^{3, 4}

1. Blood vessel factors
 - a. Vasoconstriction and retraction
 - b. Maintenance and integrity of endothelium
2. Tissue factors
 - a. Turgor
 - b. Elasticity
3. Thrombocytes (platelets)
 - a. Mechanical activity
 - b. Chemical activity

This paper is from the Departments of Urology and Hematology, The University of Tennessee College of Medicine, Memphis, Tennessee.

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- c. Anti heparin activity
- d. Anti fibrinolytic effect
- 4. Plasma factors
 - a. Thromboplastin components
(VIII, IX, X, PTA, Hageman, & V)
 - b. Accelerator factors
(X, V, VII)
 - c. Prothrombin Thrombin
 - d. Calcium
 - e. Fibrinogen Fibrin
 - f. Plasminogen (profibrinolysin) . Plasmin
(fibrinolysin).

Blood Vessel and Tissue Factors

Most urologists and surgeons who deal with elderly people recognize this as the basis of much operative and postoperative hemorrhage. The inability of a small vessel to constrict and retract, thus leaving the clotted end to the mechanical forces of catheter trauma or voiding eddies, probably accounts for many prostatic hemorrhages. It is this same type of vessel that is difficult to ligate because it has lost its elasticity and has become brittle and friable. The surrounding tissue also contributes to the stability of the clotted vessel. Where there is loss of turgor and elasticity, especially in the presence of an inflammatory reaction, the control of small vessel ooze becomes a major problem.

Steps to Control

The control of this type of bleeding may require several steps. First, pressure should be applied to the prostatic fossa and the bladder neck by tension on the catheter. We have found a pulley arrangement with two or three pounds of weight hanging over the end of the bed to be more satisfactory than taping the catheter to the calf or thigh of the patient. This same type of arrangement has been used satisfactorily with avulsion of the prostatic urethra and for control of urethral bleeding in cystectomies. Next, we try repeat fulguration of the prostatic fossa bleeders, and then may use a double bag (hemostatic) catheter which places pressure in the fossa and on the bladder neck. If these methods fail, then we must resort to open packing of the fossa with hemostatic sponges and gauze packs. We also have tied the hypogastric arteries in several cases. By the time the tension has been applied and secondary fulguration is decided upon, there has usually been time to exclude the other various factors.

This is not a common cause of bleeding because it is usually recognized early. If a thrombocytopenia purpura develops, it may be treated with steroids prior to surgery. In the occasional patient with a

low platelet count for no known reason, we try to protect the platelet supply by very careful control of hemostasis during surgery and by having available compatible donors and platelet transfusions.

Plasma Factors

Deficiencies in the various thromboplastin and accelerator factors, require skillful hemotological study to define and prepare for surgery. It is advisable to have good consultation and close cooperation with a hematologist in these patients. It would not be advisable to "go it alone" here.

Bleeding due to elevation in the prothrombine time is usually due to anticoagulation therapy or bowel sterilization, and may be corrected with vitamin K₁ therapy.

Hemorrhage due to calcium deficiency is not known except possibly where large amounts of citrated blood are given. Intravenous calcium may be given in this case.

A deficiency of fibrinogen may be corrected by intravenous fibrinogen, except where the condition is due to a chronic fibrinolysis.

The last plasma factor to be discussed is that of activation of the fibrinolytic system either locally or systemically. The system may be activated by a number of factors.^{5, 6, 7, 8, 9} Some of the more common ones are anxiety, apprehension, epinephrin, drugs of many kinds, bacterial kinases, and urokinases. MacFarlane and MacFarlane and Biggs have demonstrated some degree of activation of this system in 70 per cent of the patients in the preoperative periods.^{10, 11}

Fibrinolysis is seen in abruptio placenta and amniotic fluid embolism. It has been reported in pulmonary, pancreatic, prostatic and uterine surgery. It also occurs in electroshock, hangings and traumatic sudden death.

Normal Studies

When there is acute activation of fibrinolysis the clotting studies, including fibrinogen levels, may be normal. The most useful test is the observation of the whole blood clot for a period of four hours or more.¹² As lysis develops, the clot will have a "moth eaten" appearance and there will be an increased fall-out of red cells. As much as 50 per cent of the clot may be lysed in four hours. The method we prefer to use is to put five ml. of freshly drawn venous blood into a graduated centrifuge tube and insert an applicator stick.¹² The clot can stand at a temperature of 37° and be observed for retraction, then lysis.

When lysis is noted, we have found replacement therapy to be of little use and have abandoned it unless there is a fibrinogen deficiency due to pro-

longed lysis of clots with a result of depletion of the fibrinogen. In this case, fibrinogen is given. We have also found that nonspecific hemostatic agents, steroids, and hormones have been uniformly unsuccessful in promoting hemostasis. There are two agents that can be used for control of fibrinolysis. The first is epsilon aminocaproic acid (EACA), a synthetic amino acid similar to lysine and ornithine.² It not only is an effective anti-fibrinolytic agent, but a potent inhibitor of urokinase, a normal protolytic enzyme in the urine.¹³ EACA may be given orally, or intravenously. In generalized fibrinolysis, as measured by whole blood clot lysis, EACA should be given intravenously at a rate of one gram an hour for four hours and 0.5 grams per hour for eight hours. The infusion may be continued or repeated when necessary. This drug has specific indications for its use and should not be used as a panacea of all bleeding but only where local or generalized fibrinolysis is known or suspected.

Fat Emulsions

The other agent to be used and the one that we have been interested in is intravenous fat emulsions.^{14, 15} We have used it successfully in six patients who had postoperative hemorrhage and were demonstrated to have whole blood clot lysis. Euglobulin clot lysis or fibrin plate lysis confirmed the clinical impression. Intravenous fat emulsion controlled the lysis and hemorrhage usually within four to six hours. The required dose of fat emulsion varied between 500 and 1000 ml. In one patient, preoperative lysis was detected and was treated with a high fat diet prior to surgery with control of the lysis. In the immediate postoperative period, fibrinolysis again occurred and was successfully controlled with intravenous fat emulsion. This patient was later proven to have a chronic fibrinolysis and was sent home on a high fat diet. In one recent patient with chronic fibrinolysis, oral and intravenous fat did not control the lysis and the patient had to be treated with epsilon aminocaproic acid.

The various clotting deficiencies are a rare cause

of abnormal prostatic bleeding. Many of these may be suspected by a history prior to surgery and may be corrected. The major causes of abnormal bleeding in our experience have been those due to vessel or tissue factors and those due to activation of a fibrinolytic system. The use of epsilon aminocaproic acid or intravenous fat emulsions has proven successful in controlling abnormal bleeding due to activation of the fibrinolytic system.

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EMORY RECEIVES \$227,777 FROM HARTFORD FOUNDATION FOR STUDY OF BURNS

The Emory University School of Medicine has received a grant of \$227,777 from the John A. Hartford Foundation, Inc., for research and improved management of burn injuries.

The grant was announced by Ralph W. Burger, president of the foundation, and Dr. Arthur P. Rich-

ardson, dean of the medical school. It covers a three year period.

The funds will support continued work under the direction of Dr. John D. Martin, Jr., chairman of the department of surgery at Emory.

SERIOUS TOXICOLOGIC REACTION TO SOME COMMONLY USED DRUGS

D. Frank Mullins, Jr., M.D.; Zeb Burrell, M.D.; Hart Sylvester, M.D.; and
Norman Gardner, M.D., *Augusta*

Three cases resulting in fatality are reported.

TOXIC is derived from the latin adjective, *toxicus*, meaning poisonous. A poisonous substance, such as a drug, is a substance that in suitable quantities has properties harmful or fatal to an organism when it is brought into contact with, or absorbed by, the organism.

Poisonous Drugs

Commonly used drugs may prove poisonous. The action of many drugs is immediate and very desirable; i.e., morphine for acute severe pain and aspirin or pyralgin for joint pain or headache. The relief provided by these drugs is desired and is an immediate effect. They may also have a delayed effect that may be harmful to the organism; i.e., anemia, thrombocytopenia or hemorrhage, due to toxic depression of the bone marrow, or conprophorin excretion may be increased.¹

We were temporarily misled to think that the first case of our series was due to aspirin, because this patient suffered throughout his lifetime with headache and joint ache; however, the delayed effect of another drug, administered three months previously, appeared to have produced fatal aplastic anemia. This case is reported as follows:

Case Report One

S. L. R. A.-716: This 64 year old white male hospital attendant was admitted to another hospital because of weakness, bone aching all over and spots

in his skin ten days prior to admission. Past history was that of a life long complainer who used much aspirin because of headaches and joint aches. Three months prior to his admission, he was hospitalized for surgical repair of inguinal hernia. He was given 13 grams of chloromycetin over a twelve-day period because of cystitis. Hemogram was normal at that time. On final admission, RBC 2.8 million, WBC 900. Hemoglobin ten grams and reticulocyte count 0.1 per cent. Temperature was 101°, pulse 90, and B.P. was 130/50. Bone marrow examination revealed total marrow aplasia.

Autopsy examination revealed generalized petechial hemorrhages and ecchymoses due to decreased platelet production; aplastic anemia possibly related to chloromycetin administered three months previously. There was hemorrhage into the small and large intestine, splenomegaly and hepatomegaly. This is an example of delayed apparent toxic reaction to chloromycetin.^{2, 3}

Case Report Two

E. L., 43, WF: Asphyxiated, with laryngeal edema immediately after injection of Hypaque⁴ for I.V. pyelogram. She was admitted to the hospital because of possible renal colic and acute cystitis. This patient's urine culture showed *A. aerogenes* and pyelonephritis with partial blockage of ureter near the ureterovesical junction. Her lungs showed generalized emphysema. She was a known asthmatic patient, and no precautions such as benadryl were administered

before telepaque was injected. No skin test was performed.

Case Report Three

A. M. P., 7, CF: Death due to cardiac arrest during tonsillectomy. This patient had hemoglobin of 10.5 grams and normal white blood count on admission. She was premedicated with nembutal grains 1, atropine grains 1/150 and codeine grains one half and one ampule of adenosin. Open-drop ether produced what appeared to be normal anesthesia, but her jaws became tightly closed when the gag was inserted. Breathing stopped, heart rate was normal and throat was dry. Artificial respiration was given and she began to hyperventilate. The right tonsil was removed and very little bleeding occurred. Breathing again stopped and her heart stopped. External massage, tracheostomy and artificial respiration did not revive her.

Autopsy showed the trachea and bronchi blocked

with mucus and a little blood. There were multiple thrombi in all organs related to sickle-cell crisis.

We have used these three cases to illustrate allergic sensitivity and delayed toxicologic effects of some commonly used drugs: chloromycetin, X-ray dye and production of acute sickle-cell crisis during ether anesthesia for tonsillectomy. The authors of this paper suggest very careful evaluation of patients before these drugs are used.

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GEORGIA TUBERCULOSIS ASSOCIATION TO FINANCE PULMONARY DISEASE FELLOWSHIP

A pilot project in medical education which will finance a one-year residency or fellowship in pulmonary diseases has been established by the Board of Directors of the Georgia Tuberculosis Association. Announcement of the project was made by Dr. Joseph S. Cruise, Chairman of the Association's Sub-committee on Medical Education.

Using Christmas Seal funds contributed by local TB Associations throughout the state, the project is designed to further and improve services for pulmonary disease care in Georgia. Any person having completed two years of postgraduate medical education can apply for training under the program. Preference will be given residents in internal medicine who have completed at least one year of approved internship and a first year of general internal medicine residency or fellowship. Equal consideration will be given to those who have served a general practice residency for one year following internship.

Medical training institutions in the state which have students who may be interested in applying for funds under the project, must offer a program which includes certain elements. Among these are academic

and clinical training in non-tuberculous chest diseases; academic and clinical training in pulmonary physiology and pulmonary function laboratory; a minimum of three months academic and clinical training in tuberculosis in-patient care; and academic and clinical training in tuberculosis out-patient care. The three months of in-patient care must be taken at Battey State Hospital, Rome. Public health facilities currently being used in tuberculosis control in local areas can be used in the out-patient program.

Funds provided will be based on the pay level of the training institution for a third year postgraduate student. This is currently approximately \$4,000 per annum. Christmas Seal funds will support nine months of the training. During the three months at Battey State Hospital, that institution will provide funds based on their regular payment plan.

Applications or inquiries for further information should be submitted to Dr. Joseph S. Cruise, Chairman, Sub-committee on Medical Education, Georgia Tuberculosis Association, 5 Forsyth Street, N.W., Atlanta, Georgia.

NOTICE TO GEORGIA GENERAL PRACTITIONERS

The site of the FIFTEENTH ANNUAL SESSION of the
GEORGIA ACADEMY OF GENERAL PRACTICE

October 10-12, 1963

has been changed from

THE AQUARAMA, JEKYLL ISLAND, GEORGIA

to the ATLANTA AMERICANA MOTOR HOTEL, ATLANTA, GEORGIA

AGING SKIN

THE CHANGES IN COVERED AND EXPOSED DERMIS

J. Graham Smith, Jr., M.D., *Durham, North Carolina*

A review of the histochemical and biochemical changes in the dermis occurring with age and chronic sun damage is presented.

UNNA¹⁴, one of the first to study chronically sun damaged skin (actinic elastosis) histochemically, appreciated that striking changes occurred in exposed but not in covered skin. Indeed, it is a common clinical experience to observe persons of Scotch-Irish ancestry who freckle easily, tan poorly, and appear to be much older than they really are. If covered areas, as for example the lower abdomen, are examined in such people, their skin usually appears considerably younger than skin on exposed areas. Conversely, it is a common experience to have difficulty judging the age of Orientals and Negroes. This is because of the natural protection from the sun given by their increased pigmentation and possibly, also, differences in the stratum corneum.

Aging Versus Sun Damage

A. Histologic Changes

As a function of age, there are few histochemical changes observable in the human dermis. A slight decrease in neutral and acid mucopolysaccharide staining occurs. There is, also, slight thickening or coarsening of the collagenous fibers. Elastic fibers are unchanged or decreased slightly.⁴ Sun damaged skin, however, shows remarkable alterations.¹³ There is an

increase in neutral and acid mucopolysaccharide staining using the periodic acid-Schiff stain for neutral mucopolysaccharides and the Mowry colloidal iron or alcian blue stain for acid mucopolysaccharides. With toluidine blue stains there is marked basophilia in the upper parts of the dermis and the collagen in this area stains atypically with the Mallory trichrome stain and luxol fast blue suggesting a major alteration in the collagen. In addition, there is an enormous increase in fibers which take the classic elastic tissue stains such as orcein, Verhoeff's and aldehyde fuchsin. These fibers are digested by the enzyme elastase but not by pure collagenase or crystalline trypsin.⁷

B. Mucopolysaccharides

Hexosamine is an essential component of glycoproteins, neutral and acid mucopolysaccharides.⁸ Because of the decrease in neutral and acid mucopolysaccharides found histologically with age and the increase found in sun damaged skin, it was to be expected that the hexosamine would be found to decrease with age³ and increase in sun damaged skin.¹⁰ In sun damaged skin the increase in hexosamine has been demonstrated in the upper dermis in the area where the histologic changes are seen.¹⁰ Hexosamine is decreased in the lower dermis of sun damaged skin so that, biochemically, it has been possible to localize the hexosamine alteration just as the abnormalities are localized histochemically. In addition, Loewi⁶ has demonstrated quantitatively decreased acid mu-

This paper is from the Division of Dermatology, Department of Medicine, and the Center for the Study of Aging, Duke University Medical Center, Durham, North Carolina.

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copolysaccharides occurring with age in human skin especially hyaluronic acid with increased acid mucopolysaccharides in the exposed skin of the hands with a particular increase in hyaluronic acid (see Table).

C. Non-Fibrous Protein

The non-fibrous protein or ground substance of the dermis is an undefined mixture of serum proteins, glyco- and mucoproteins, other non-collagenous proteins and water. Although undefined, the non-fibrous protein can be measured approximately and has been found to decrease with age in man, whereas, it is increased in sun damaged skin.¹²

D. Collagen

One third of the total body protein is collagen and half of the total collagen is in the skin. In aging unexposed dermis there is an increase in the total amount of collagen which is, however, less soluble than young collagen.¹² This loss of solubility of collagen with age is presumably due to progressive cross-linking and polymerization and may be an extremely significant aspect of aging connective tissue throughout the body.² The total collagen in sun damaged skin is decreased but is more soluble than normal and may be profoundly altered as evidenced by its decreased proline and hydroxyproline in relation to nitrogen content.¹²

E. Elastin

In adults there appears to be little change in elastin with age; however, there is an enormous increase in elastin in sun damaged skin. The elastin is increased from two per cent to as high as 13 per cent of the dry weight.¹¹ That this is true elastin appears to be well-established, based on its solubility, enzyme susceptibility, morphology, tinctorial and physical properties, and amino acid composition.⁹

F. Saline Reabsorption

The time taken for 0.2 ml. physiologic saline to be absorbed from the dermis may be referred to as the Saline Reabsorption Test (SRT). Saline is reabsorbed more rapidly in the skin of children and young adults than older adults and also is reabsorbed more rapidly in certain diseases such as nephrosis and pneumonia.¹ Children and adults under 50 reabsorb the saline in approximately one hour. Older adults, over the age of 50, require an average of two hours for reabsorption of the saline wheal. Because of the changes found with age and the other differences found in sun damaged skin as compared with aging skin, the SRT was performed on 13 adults on exposed areas, usually the forearm, and unexposed areas, such as the abdomen.⁵ These 13 adults required approximately two hours for the wheals to reabsorb from covered areas; however, in the areas

TABLE
ACID MUCOPOLYSACCHARIDES (AMPS) IN HUMAN SKIN
(Per cent of dry defatted skin)

	Newborn (pooled)	Leg, Abdomen 55 yr. old	Abdomen 70 yr. old	Hand (pooled) 50-70 yr. old
Total AMPS	.29	.17	.09	.23
Hyaluronic Acid	.16	.07	.03	.12
Chondroitin Sulfate B	.11	.09	.05	.09

(Modified after Loewi, G., *Biochim. Biophys. Acta* 52:435, 1961).

of chronically sun damaged skin, the same elderly adults invariably reabsorbed the saline wheals in only one to 25 minutes.

Discussion

Profound changes occur in the dermis with age and chronic sun damage. These changes are quite different and peculiarly, although clinically we associate sun damage changes with age, the biochemical alterations are more similar to the changes in young skin. The significance of this appears to be that depolymerizing collagen or increasing acid mucopolysaccharides, especially hyaluronic acid, is not likely to make the skin appear younger. Indeed, the only technics which do alter the appearance of sun damaged skin causing it to appear younger involve destruction of the skin by such means as surgical planing or caustics such as trichloroacetic acid or phenol resulting in the synthesis of new connective tissue. As evidenced by the lack of sun damage changes in individuals with natural protection such as Orientals and Negroes, the only practical approach to this problem at present appears to be the avoidance of excessive exposure to sun and the use of artificial sun screens.

Summary

1. The histology and biochemistry of aging and sun damaged human dermis has been compared.
2. The clinical, histochemical, and biochemical changes in aging covered and aging exposed dermis are quite different.
3. The prevention of changes due to chronic sun damage in susceptible individuals is recommended by the avoidance of excessive exposure to sunlight and use of artificial sun screens.

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SMITH / Continued

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THE PURPOSE of the adjoining map is to "star" those cities or communities in which a member of the medical profession during the past month addressed some civic group—in an effort to tell medicine's story to the public.

Of some 3,000 doctors of medicine in Georgia, just four talks were reported for the entire state. If the public is to understand the profession's views and learn about our system of health care, then certainly it is the doctor's responsibility to speak for medicine.

Four physicians fulfilled this responsibility last month. Four out of 3,000—so let's make it your responsibility next month. Speak up, doctor, and truly serve the aims and ideals of medical practice. It's your turn now.

How well are we telling our story?



AMENORRHEA OF PITUITARY ORIGIN

William C. Shirley, M.D., *Macon*

Four illustrative cases are reported and discussed.

A MENORRHEA in a woman in the childbearing age is a diagnostic challenge which must be met frequently by the gynecologist. The anxiety and apprehensive questions which accompany this condition are familiar ones to all of us. The tendency to place too much emphasis on this anxiety, with failure to evaluate the pathologic conditions which may produce amenorrhea, is a fault which, I believe, is almost universal. This common fault is one we share with our referring general practitioner as these patients have usually been on some unsuccessful hormone therapy before ending up with the gynecologist. This failure in treatment, of course, adds to the patient's anxiety and often clouds the history. It is to be emphasized that amenorrhea, resulting from pituitary failure, congenital anomalies, ovarian failure and systemic disease cannot be corrected with ovarian-like hormones; therefore, a thorough diagnostic search must be carried out to eliminate these conditions as a possible cause of amenorrhea.

Normal Causes

There are numerous causes of amenorrhea that are normal and physiological such as pregnancy, lactation, adolescence, menopause, bilateral oophorectomy and radiation. These are mentioned to emphasize the importance of eliminating the obvious before beginning the search for an underlying pathological cause. These can usually be ascertained by a careful history, general physical and pelvic examination. If these be eliminated, the burden of proof then lies with us.

Congenital anomalies can usually be eliminated by a careful history and pelvic examination. Systemic diseases test the gynecologist's diagnostic ability and when in doubt, these patients should be referred to a competent internist for evaluation before proceeding with the work-up. Progesterone is a valuable practical diagnostic aid. If bleeding occurs following the administration of progesterone it may be concluded: 1. Endogenous estrogen is being produced. 2. A responsive endometrium is present. 3. Pituitary activity is present and 4. The amenorrhea is not due to pregnancy. If bleeding does not occur and the lady is not pregnant, the amenorrhea is on a uterine, ovarian or pituitary basis. A twenty-four hour urine for gonadotropin will help distinguish between ovarian amenorrhea and pituitary amenorrhea. If pituitary gonadotropin are high, it would indicate ovarian failure and if low, probably pituitary in origin.

Pituitary Origin

This paper deals primarily with amenorrhea of pituitary origin, and a report of four cases which have occurred in our practice. Pituitary suppression due to tumors or hyperfunction of other glands producing high levels of estrogen, progesterone or androgen which suppress the anterior pituitary (ovarian cyst, granulosa cell tumors, the comas, functioning ovarian tumors, adrenogenital syndrome, adrenal cortical cancer, Cushing's syndrome, Stein-Leventhal syndrome, thyroid disorders, and excessive cortisone administration) must be kept in mind. The most frequent cause of pituitary failure in women is infarction at the time of a traumatic delivery, usually associated with severe hemorrhage and shock.

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SHIRLEY / Continued

Sheehan's syndrome should be considered first in a patient giving a history of amenorrhea or scanty irregular menstruation following a traumatic delivery. The severity of the syndrome depends upon the amount of pituitary damage. The amount of pituitary damage may be small and the remaining anterior lobe may have sufficient functional integrity to permit re-establishment of normal cycles and fertility. Two cases are presented from our practice to illustrate this syndrome.

Case Report One

This 25 year old, G-III, P-II, A-0, was seen three years ago as a new obstetrical patient. She was about three months pregnant at the time. Her two previous deliveries were in another city and she described them as uncomplicated. Her past history was not remarkable except that she had received an electrical shock by lightning, which apparently was not too severe. Her prenatal course was uneventful except for a persistent sinus infection. She had a spontaneous delivery one day prior to her estimated date of confinement. Bleeding was within normal limits and there were no complications. She was dismissed five days later. Thirteen days later, she returned to the emergency room with profuse vaginal bleeding. A diagnosis of subinvolution of the uterus with possible retained products of conception was entertained. A Fibrinogen level was obtained which was reported as 140 mgms. Five cc's of blood were drawn and placed in a clean dry test tube. This blood showed poor clot formation at the end of ten minutes. Enough blood was drawn when testing for clot formation to type and cross match for five pints of blood. Intravenous Pitocin was started and she was taken to the operating room for intra-uterine examination and possible removal of retained products. Intra-uterine examination revealed no retained products. The uterine cavity was packed with a Torpin packer. Two units of Fibrinogen were given as soon as it was available. This was followed by five pints of blood, vitamin K, calcium gluconate and premarin. During the intra-uterine examination, blood pressure dropped to 70/40 and remained there until the Fibrinogen was given and the second pint of blood administered. Her blood pressure then returned to a normal level and remained normal. She remained in the hospital for six days. Her bleeding after this was minimal.

Post-partum Examination

Her post-partum examination revealed normal pelvic examination except that after three months, menstruation had not resumed. Four months after

delivery she received one injection of progesterone but failed to menstruate. This was followed six weeks later by another injection of progesterone which was followed five days later by a slight spotting for three days. Urinary Gonadotropins, PBI and 17 Keto steroid tests were not available in our laboratory at this time. A clinical diagnosis of Sheehan's syndrome was made on the basis of her history of delayed post-partum hemorrhage and failure to resume menstruation, even after two injections of progesterone. At this time, six months after delivery, her husband was transferred to a neighboring city. She was placed on thyroid, premarin and progesterone by her local physician and she resumed some semblance of a cycle with a scanty flow. After several months of this therapy, it was discontinued to see if ovulation might resume. After cyclic therapy was discontinued, she had several episodes of spotting about two or three months apart. Two years after delivery, her menstruation began to resume a more regular nature with increased flow. Recently, I received a letter from her obstetrician stating that she was three months pregnant. I believe that this represents a Sheehan's syndrome with a small infarct. Apparently, the volume of the pituitary damage was small and the gland was left with enough functional integrity for menstrual periods to resume and pregnancy to occur. I am anxiously awaiting to see what her menstrual periods do after this delivery.

Case Report Two

This 33 year old, G-I, P-0, A-0, was admitted to The Macon Hospital in early labor. Her prenatal course had been uneventful and her labor progressed normally. Her delivery was complicated by a fibrinogen depletion with post-partum hemorrhage. She received two units of Fibrinogen and three pints of blood. Her urine output remained good and the hemorrhage was controlled. On her seventh post-partum day, she had what appeared to be a mild cerebral vascular accident with facial weakness on the left, and right arm and leg weakness, but there was no paralysis. She was given sparine 25 mgms. by the internist who had been called into consultation when cerebral accident was suspected. Shortly after the administration of this drug, her respiration became markedly embarrassed and a tracheotomy was required. It was felt that this represented an allergy to the sparine rather than resulting from the cerebral-vascular accident. She was maintained on diminishing doses of solu-cortef for several days. Her condition improved steadily and she was dismissed from the hospital ten days later, although her sensorium cleared and her right arm and leg weakness disappeared, her facial weakness persisted.

Follow-up

She was seen for regular post-partum check-ups and it was noted that four months after delivery, her menstrual periods had not resumed. She complained of feeling weak and having no energy. There was no fern pattern of her cervical mucus. Sheehan's syndrome was suspected and this was confirmed by a low PBI and 17 Keto steriods. She has been maintained for the past nine months on cyclic therapy utilizing premarin 1.25 for 20 days of the cycle and starting on the 15th day of the cycle enovid 5 mgms. for 10 days. The dosage of these two hormones has been varied according to the patient's response. She also has been maintained on cortisone and thyroid daily. It is felt that this patient represents a classical picture of Sheehan's syndrome resulting from the complications surrounding her delivery.

Tumors

Pituitary failure may also occur from tumors, the most common of which is chromophobe adenoma. Amenorrhea is usually the first manifestation of pituitary failure. It may be some time before other signs of pituitary failure develop. We feel an X-ray of the sella turica is a valuable diagnostic aid in determining etiology of amenorrhea. Urinary Gonadotropins, PBI and 17 Keto steriods may also be of help in determining the presence of these tumors.

The presence of gonadotropins in the urine does not necessarily rule out the presence of chromophobe adenoma, as it has been recently established, contrary to past belief, that some chromophobe adenomas may secrete gonadotropins. Visual changes and headache may be part of the history. The changes in vision may be so insidious that the patient may have difficulty in recognizing them. When visual changes are noticed by the patient, the tumor is usually well advanced and therapy must be carried out at once if vision is to be saved. If tumor is suspected, we always get a visual field study. Impairment of vision may determine the choice of treatment and the rapidity with which it should be carried out. We have had two cases of chromophobe adenoma in our practice in the past three years; one was treated by radiation and surgical removal and one by radiation alone. These two cases are presented.

Case Report Three

This 31 year old, G-0, P-0, A-0, was referred by her local physician because of amenorrhea of nine years duration. She stated her menstrual periods began when she was 15 years of age and were regular for three years. She then began to skip periods and her flow became scanty. Seven years after beginning her menses, her periods stopped and she had not menstruated for the past nine years. She had been

married eight years but had never become pregnant. A complete symptom review failed to elicit any other symptoms suggestive of endocrine hypofunction. Pelvic examination revealed an infantile size uterus and there was no fern pattern of the cervical mucus. There was no response to injection of 100 mgms. of progesterone.

We have made it a policy to obtain an X-ray of the sella turica on all patients who have unexplained amenorrhea of six months duration. Her X-ray showed typical enlargement of the pituitary fossa of an intrasellar expanding lesion and there was little doubt that this was a pituitary adenoma of the chromophobe type. A visual field study was obtained and there were no visual field or visual acuity changes. Since this patient's vision was not damaged, it was elected by our neuro surgeon to treat this patient with radiation therapy. This was carried out with weekly visual field examinations to be sure there were no changes. She has now been returned to her local physician with suggestion that he maintain her on cyclic estrogen and progesterone therapy and thyroid and cortisone according to her clinical needs and laboratory findings.

Case Report Four

This 30 year old, G-II, P-II, A-0, was seen complaining of amenorrhea for the past ten months. Her menstrual periods started at the age of 12 years and had been regular with normal flow until ten months ago. Her last two periods prior to her amenorrhea were at the regular time but were scanty. She had been delivered by us in 1952 and in 1956, some eight and four years prior to this visit. Her pregnancies were normal and her deliveries uncomplicated. Pelvic examination revealed a mild cystocele and rectocele. Her uterus was smaller than average and in a third degree retroverted position.

There were no other findings except she complained of a vague headache behind her right eye. There was no response to 100 mgms. of progesterone and a skull X-ray revealed findings strongly suggestive of pituitary tumor. Her 17 Keto steriod, PBI and urinary gonadotropins were within normal limits, but there was no fern pattern of her cervical mucus. A visual field study revealed definite early bitemporal hemianopia probably due to pituitary tumor compressing optic chiasma from below. It was decided, since her visual damage was minimal, that radiation would be tried. She was given 15 treatments with cobalt irradiation; however, she continued to have right temporal headaches and some diminution of visual acuity in the right eye. It was decided that she should have surgical extirpation of the tumor.

On November 4, 1960, through a right frontal craniotomy, the pituitary region was explored and

the neuro surgeon described a large tumor pushing superiorly and anteriorly upon the optic nerves. This tumor was enucleated and the pathological diagnosis revealed that the tumor was a chromophobe adenoma with degenerative changes. She did well post-operatively and is now being maintained on: 1. cortisone acetate 12.5 mgms. daily; 2. thyroid gr II daily; 3. 150 mgms. testosterone, 25 mgms. estro-dial implanted by pellet every six months; and 4. progesterone 10 mgms. daily from 20 through the 25th day of each cycle. This, of course, can be varied according to her clinical response. Her visual damage has remained minimal, and her headaches are gone. She is doing well but requires close supervision and correct maintenance therapy.

Amenorrhea is described with particular emphasis

on amenorrhea of pituitary origin. Four cases are presented — two of Sheehan's syndrome and two chromophobe adenomas. One of the cases of chromophobe adenomas was treated with radiation and one with radiation and surgery. The problem of diagnosing and treating amenorrhea is explored emphasizing that, although all amenorrhea need not be treated, the cause of all amenorrhea should be established and proper therapy carried out when indicated.

740 Hemlock Street

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AN UNUSUAL COMPLICATION ASSOCIATED WITH OMPHALOCELE

James E. Anthony, Jr., M.D., and William G. Brawley, M.D., *Decatur*

A successful surgical correction is reported.

A FECAL FISTULA at the umbilicus in the neo-natal period is usually due to a patent omphalo-mesenteric duct. In the presence of an omphalocele, such a fistula may be due to a pinching of a knuckle of bowel in the sac by a cord clamp or tie. A fecal fistula following immediate repair of an omphalocele is quite unusual. The following case is such an example.

Case Report

J. D., Hospital No. 71538, was a full term, white male infant born on 7-26-59 at 11:22 P.M., of a healthy 34 year old gravida 3 para 2 mother. The birth weight was 7 lbs. 10 ozs. He cried lustily at birth and was found to be in good health. About 36 hours following delivery it was noted that the umbilical cord was protruding and "apparently filled with fluid." On 7-29-59 a note by W. G. B. read "baby has umbilical hernia with small omphalocele. Mass may be reduced with fingers."

On 7-29-59 at 6:00 P.M. the patient was seen by J.E.A. and the enlarged cord was noted. At that time the cord was beginning to blacken in areas and bowel seemed to fill the base of the cord. There was a beginning drainage of small amounts of yellowish fluid and rupture of the cord appeared imminent. It was felt that this was a typical small omphalocele, which was beginning to leak peritoneal fluid. Because of the fear of peritonitis, either present or potentially so, the baby was immediately taken to surgery.

Although the defect at the umbilicus was small, it was felt that any dissection or repair of the defect

in the presence of peritonitis was not indicated. Consequently, after cleansing the cord, and under local anesthesia, using one half per cent procaine, lateral flaps of skin were raised and sutured over the cord stalk. The baby withstood the procedure well, was started on penicillin and streptomycin and begun on its formula. A secondary repair was planned as soon as every evidence of infection was gone. On the night of surgery, the baby looked good, ate well and had normal bowel sounds. On the third post-operative day, however, a small amount of yellowish purulent material began to drain from the wound, which by now had become inflamed. This progressed rapidly to frank feces and a fecal fistula was obviously present.

Considerations

We considered the possibilities that the fistula might be due to a crushing of the colon or terminal ileum by the cord clamp, perforation of a loop of



Figure 1

Closure of skin over cord stump, day of surgery.

bowel by suture, or the remote possibility that this might have been a patent vitelline duct, temporarily hidden by a covering of skin. Since the patient's condition was stable, it was decided to let him go home, feeling that the fistula would probably close spontaneously since the baby had been having stools by rectum. The following day while the parents were being shown the fistula and being instructed in its care, the wound opened and a loop of bowel extruded before the startled observers. The bowel, which presented a mucosal surface, continued to extrude until the typical "T" shaped mass appeared, as in Figure 2. The mass had the appearance of a transverse colostomy which had prolapsed both proximal and distal limbs. The baby was undisturbed by this unexpected development and since it appeared to be a functioning colostomy, it was decided, with support by a consultation with Dr. Lea Richmond to follow a watchful course.

Journal Reference

Because of the "stalk" of the protruding bowel, it was impossible to get a glass rod under the colostomy. At this point, an article by Johnston¹ in the *British Journal of Clinical Practice* was found which included a photograph very similar to Figure



Figure 2

"T" shaped mass protruding from wound, fourth postoperative day.

2. The possibility of this being a prolapse of bowel through a patent vitelline duct was then seriously considered. The abdominal stoma drained soft yellow stools and little or no stool came through the rectum. After several days, the fecal drainage began to cease and the baby began to have normal stools through the rectum. At this point he was discharged to be followed as an out-patient with a barium study of the colon to be done after the baby was a bit stronger. Three weeks after birth the patient appeared in the office after rapid return of the bowel to the abdomen, which had occurred within a few hours. Barium studies were then made of the colon which showed no particular abnormality and no area which might have been the "colostomy" site. In several days the navel had healed, he was gaining weight and passing normal stools. Since then, there has been no evidence of a hernial defect at the umbilicus.

Discussion

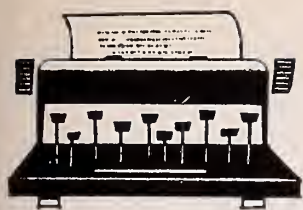
Although it is tempting to consider this a patent vitelline duct due to the striking resemblance of the lesion to the characteristic "T" or sausage shaped appearance of such an anomaly, we have no direct supporting evidence for this opinion. Most instances of a patent omphalomesenteric duct in the neonatal period make their appearance after the cord has sloughed from the navel. If the fistulous tract is broad and intraabdominal pressure high, the ileum may prolapse through the mucosal lined tract and result in the protrusion of a large sausage shaped mass attached at its mid portion to the navel. Barium studies of the colon were not done in the hospital because we did not wish to add any unnecessary trauma to the infant. It was felt that after gaining sufficient strength at home, a barium enema could be performed at leisure. Unfortunately, at least as far as this paper is concerned, the bowel rather suddenly returned to the abdominal cavity before these studies could be made. Because we have no evidence of this being a patent omphalomesenteric duct, except for the characteristic appearance seen in Figure 2, we must consider the possibility that this might have been the result of injury to the colon or ileum, either by a cord clamp or at the time of surgery.

We have found this case to be interesting, however, and have reported it because of the lack of ill effects the transversostomy or ileostomy had upon the child, the rapid disappearance of the mass and the unusually rapid healing of the fistula. When seen almost four years later, the umbilicus was well healed with no evidence of fistula or hernia.

558 Medlock Road

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The Role of the Thymus Gland

FOR MANY YEARS, the function of the thymus gland in health and in disease has been obscure. It has been recognized as an apparently vestigial lymphoid structure, well developed early in the life of the mammal, but undergoing significant atrophy with age. Its relation to so-called status thymicolymphaticus and sudden death has been increasingly in doubt. The beneficial effects of thymectomy in selected cases of myasthenia gravis, reported over 20 years ago,² aroused considerable clinical interest, but were not readily explicable. Recent studies, however, have assigned to the thymus major significance as the principal primordium of the mammalian immunological system¹ and the chief source of lymphoid cells. Experimental evidence for this conclusion has largely come from observations on the effects of thymectomy, carried out during the neonatal period. Thus, in mice, it was demonstrated that thymectomy leads to a marked reduction in the immune response to skin homografts, and to a severe depletion of the lymphocyte population.⁷ When thymectomized mice were grafted with thymus tissue during the neonatal period, the capacity to reject the skin grafts was restored. It was also noted that neonatally thymectomized mice ultimately developed a wasting disease with diarrhea, and died prematurely. Similar effects were recently observed in the golden hamster,⁸ with thymectomy early in life leading to the atrophy of lymphoid tissues, in an absolute lymphocytopenia, in wasting disease, and in generally impaired immune responses, such as the ability to produce antibodies to serum albumin and to reject skin grafts. As in mice, these effects of thymectomy were most significant when the operation was carried out early in life. Similar results have been noted with rabbits, rats and guinea pigs. The view is therefore gaining credence that early in life, the thymus may be the principal seed-bed of immunologically competent cells from which are derived the immunologically competent cells of the "second level" immunological organs, such as the spleen, bone marrow, lymph

nodes, etc. There is considerable evidence to suggest that these cells are actually distributed from the thymus to the peripheral organs, and that this seeding in most mammals takes place chiefly in neonatal life, with the possibility of a continuing transfer at a slower rate later in life as well. However, there is evidence that the thymus may also produce a humoral factor involved in the development of lymphoid cells.⁶

In the Limelight

With the thymus in the limelight as an organ of prime immunologic importance, it was not long before links were sought between the thymus and diseases associated with disturbance of immunologic function. Thus, in this country, Good⁵ and his associates have drawn attention to a number of interesting clinical relationships. In acquired agammaglobulinemia, for example, benign thymomas are frequently encountered, but no abnormality of thymus structure has been related to the congenital recessive, sex-linked agammaglobulinemia. However, in the so-called Swiss type of agammaglobulinemia, vestigial thymus glands and an extreme depletion of lymphoid tissue have been noted. In ataxia-telangiectasia, in which there is a congenital absence of the thymus, immunological unresponsiveness and hypogammaglobulinemia occur. Of special clinical interest are studies seeking to relate the thymus to the so-called auto-immune diseases. This approach has been vigorously developed by Sir Macfarlane Burnet³ in Australia, who further attempts to bring the findings into harmony with his clonal selection theory of immunity. Greatly simplified, this theory may be summarized as follows:

1. The specificity of antibodies is genetically determined and resides in so-called immunologically competent cells, and is transferred by genetic mechanisms, such as cellular descent, mutation, and selective proliferation.

2. The antigen merely serves as the stimulus

which activates the appropriate immunologically competent cells into such activities as antibody production.

3. During embryonic life, cells which could react with body components are suppressed, so that the normal adult fails to react with the antigenic components of his own tissues.

4. Occasionally, immunologically competent cells arise by mutation, possibly in the thymus, and the descendants of these cells, the "forbidden clones" persist and are distributed to other organs, and later in life react with various antigenic host components to give rise to various forms of auto-immune disease.

Evidence

Burnet cites some of the circumstantial evidence linking the thymus to auto-immune disease. In the normal thymus, lymph follicles with germinal centers are conspicuously absent. However, in a naturally occurring hemolytic auto-immune disease of mice, the thymus glands were found to contain lymph follicles with germinal centers, possibly representing the "forbidden clones." It is of considerable interest that such germinal centers are likewise encountered in the thymus glands in myasthenia gravis.⁴ Burnet, Good, and others have also been impressed in how many other respects myasthenia gravis fits the pattern of other auto-immune diseases, such as the frequency of occurrence in young females, the association with rheumatoid arthritis, and the occasional finding of lupus erythematosus cells. It is also noteworthy that the thymus is highly susceptible to stress, presumably through corticosteroid action, and that these compounds occupy such a prominent place in the management of auto-immune diseases. As Burnet suggests, it is now of great interest to ex-

tend observations of the thymus to other auto-immune diseases, and perhaps even consider possible benefits to be derived in selected cases from thymectomy or thymic irradiation.

Further Correlation

While the function of the thymus, especially in the neonatal period, as the prime organ of lymphoid cell production is finding ample support, the factual evidence linking it to auto-immune disease is still circumstantial, as Burnet himself indicates. It certainly now calls for further experimental and clinical correlations in a variety of diseases regarded as auto-immune in nature, such as lupus erythematosus or rheumatoid arthritis. On the occasion of a visit to Atlanta in 1962, Burnet remarked that 1963 might well be the "Year of the Thymus," and judging by the accelerated pace of studies of this organ which have already appeared this year, his prediction is coming true.

Morris Tager, M.D.

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Psychotherapy with the Family in Schizophrenia

THE PSYCHOTHERAPY of schizophrenia and other serious types of psychiatric conditions has received varying attention through the years, depending on the currents of professional opinion in psychiatry. The psychoanalytic method of treatment was abandoned early because of these patients' lack of an organized, responsible participation necessary for classical analysis. In recent years some dynamically oriented therapists, nonetheless, undertook the pains-

taking task of conducting intensive, long-term psychotherapy with more or less selected schizophrenic patients. They soon realized that their own personal, emotional commitment to this work had to make up for the patient's shortcomings. This sort of therapeutic work requires great patience, determination, hope, and an awareness of one's own inner psychology. The childishness of the psychotic's behavior eventually interlocks with the infantile expectations trans-

ferred to the benevolent figure of the therapist, and, in successful cases, eventually the relationship between patient and doctor makes up for certain gaps left by the patient's early life.

Family Problems

There had always been a suspicion that the problems of the family were in some way casually related to the psychiatric condition of the patient, but it is only within the last decade that psychiatry has gotten around to dealing with the family as the unit of study and treatment, and has come to realize the full impact of the family concept of illness. Those who in recent years have applied the method of conjoint family psychotherapy to schizophrenia have done so for theoretical and practical reasons. The theoretical concepts of dynamic psychiatry (oral satisfactions, Oedipus complex, sibling rivalry, etc.) pertain to an implicit family frame of reference. Unfortunately, the average schizophrenic patient cannot assume responsibility for supporting the central rationale of psychoanalytic therapy—*viz.* exploration of the family roots of one's unconsciously determined conflicts. The same rationale may become applicable, however, if the family as a whole undertakes joint therapeutic exploration.

The various groups doing family psychotherapy throughout the country have arrived at strikingly similar observations: that the primary patient is a manifest symptom and scapegoat of a very disturbed family; that the seemingly bizarre psychotic symptoms of the patient "make sense" when they come to be seen as adaptive responses to a crazy, impossible family situation; that the dormant, yet interconnected, personality problems of the rest of the family members are revealed in all their malignant intensity; that the marriage between the parents of the patient is a seriously disappointing one, and each parent has turned to their soon-to-be-ill child for emotional satisfaction and uses that child to live through past, unfulfilled longings; that the psychosis of the patient is frequently a rebellion against a role foisted upon him; that in the process of family therapy the patient soon loses his overt psychotic symptoms, and other members of the family may

temporarily develop symptoms; and that the whole family is then left in an emotionally needy state and new ways of fulfilling needs have to be found, etc.

While these findings are only a sample and by no means exhaust the enormous complexity of issues involved, they do nonetheless raise fundamental questions about the whole nature of psychopathology. That is, older concepts of psychiatric illness as residing within the boundaries of a single individual have to be revised to include interactional concepts, both conscious and unconscious, between people closely involved with each other. Further, most psychiatric textbooks have written descriptions of schizophrenics based on their ward behavior—where they are described as withdrawn, living in a world of their own, detached, etc. Yet, the behavior of these patients frequently changes remarkably to that of an emotionally over-involved person when seen in the presence of family members. Which description, then, is more accurate of the schizophrenic?

Difficult Evaluation

The results of the family approach are still extremely difficult to evaluate. There has not been sufficient experience with the approach or rigorously controlled comparative studies. Although it can be expected that extensive investigation of interconnected emotional problems will result in more stable, long-range therapeutic results, we are not prepared by any means to say that by seeing the family together we can indeed "cure" schizophrenia. The family approach has promise in conditions which have proven to be relatively recalcitrant to one-to-one psychotherapy. It is likely that systematic work with families where there is a delinquent or psychosomatic member will also be fruitful. In the hard core psychosomatic patient it may be a most useful adjunct of the often non-specific medical care of chronic, treatment-resistant cases.

*Ivan Boszormenyi-Nagy, M.D., and
James L. Frano, Ph.D.,
Eastern Pennsylvania Psychiatric
Institute,
Philadelphia, Pennsylvania*

DEPENDABLE BLOOD DONORS

The surgical patient as his own blood donor is a safe, inexpensive and readily available source of blood for later transfusions, three Chicago physicians reported in an exhibit. MDs George Milles, Hiram Langston and William Dalessandro summarized a study of 113 patients who, before undergoing surgery, donated blood

for their own use. Some 62 per cent of the blood required for these patients was their own, the MDs said. Such procedure circumvents the hazards of hepatitis and inexact matching of blood types, they said.

Reprinted from the AMA NEWS, June 24, 1963.

Why the burglar threw the Savings Bonds into the Passaic River



By the time Mrs. Lorraine Klamerus of East Rutherford, New Jersey, realized her Bonds were missing, they'd been lying on the bottom of the Passaic River for days. Still inside her strong-box.

The burglar threw them there after he found out they were worthless to anyone but Mrs. Klamerus.

As it turned out, the burglar was caught. Even if he hadn't been, Mrs. Klamerus wouldn't have been out a penny on her Bonds. For the Treasury Department keeps a microfilm record of every Bond sold, and replaces them at no cost to the owner.

This is just part of the guaranteed safety you get with U.S. Savings Bonds. And part of the

reason millions of American families build their own strength and that of the nation this timely way. This strength is especially important now when the enemies of freedom are growing tougher every day.

Start buying Savings Bonds now, and see if you don't feel pretty good about it.

Quick facts about U.S. Savings Bonds

- You get \$4 for every \$3 at maturity
- You can get your money any-time
- Your Bonds are replaced free if lost, destroyed, or stolen
- You can save automatically on Payroll Savings

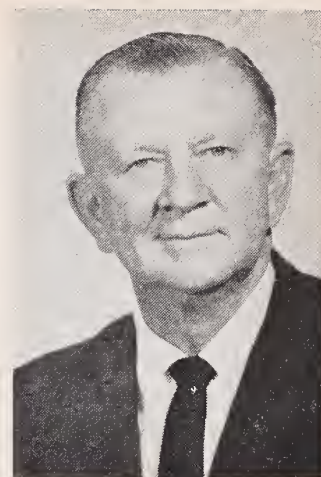
Help yourself while you help your country
BUY U.S. SAVINGS BONDS

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MEDICINE AND RELIGION

GEORGE R. DILLINGER, M.D.



THE PRACTICE OF MEDICINE is an art based on certain sciences. It is not now, nor can it ever be, a strict science.

Before the dawn of recorded history, the priesthood found that faith and religious zeal were not enough to cure certain illnesses. Priests, therefore, became the first physicians.

Neglected Spirit

In the development of modern medical education, the scientific approach has often dominated the entire field. The spirit of man has been neglected, often with disastrous results. How often has the physician treated the patient, with the best of scientific precision and care, only to have the patient succumb to a minor ailment? In such case the patient was not emotionally or spiritually prepared to endure illness, or had little faith.

Man or woman is a whole being, who must be treated as an entity. He may be mentally, socially, spiritually or physically ill, but usually any illness has more than one of these factors present. Nothing is accomplished by curing the physical and having the patient die of fear.

In modern medical practice frequent decisions are necessary, often involving life or death. For the patient and his family to have the best of care, consultation between the physician and clergyman is necessary. Physical, mental, spiritual or social illness, weakness in any of these factors, aggravates the others.

In September 1961, the American Medical Association established a Department of Medicine and Religion. The purpose is to create better communication between the physician and clergyman, so that it will lead to more effective care and treatment of the ill patient.

The dramatic color movie, "The One Who Heals," should be viewed by every physician and clergyman.

Faith

The ill man who would be cured of his illness, must have faith. Faith in God, faith in his physician, and faith in his fellow man.

Luke, the Physician, nearly two thousand years ago, quoted the Master, "They that are whole need not a physician, but they that are sick."

A handwritten signature in cursive script, reading "George R. Dillinger".

President, Medical Association of Georgia

1963-64 CALENDAR OF MEETINGS

State

September 20-21—Georgia Heart Association, Fifteenth Annual Meeting and Scientific Sessions, Biltmore Hotel, Atlanta.

September 26-27—Symposium on the Management of Retinal Detachment sponsored by the Department of Ophthalmology, Emory University School of Medicine, Fulton County Medical Society's Academy of Medicine, Atlanta.

September 30-October 4—"Five Days of Internal Medicine," sponsored by the Department of Medicine, Emory University School of Medicine, Atlanta.

October 17-19—Emory Postgraduate Seminar in Gynecology and Obstetrics offered by the Department of Gynecology and Obstetrics, Emory University School of Medicine, Atlanta.

December 5-6—Fifth Annual Postgraduate Course in Ophthalmology of the Emory University School of Medicine, Grady Memorial Hospital, Atlanta.

May 3-6, 1964—110th Annual Session of the Medical Association of Georgia, Macon, Ga.

Regional

July 15-20—Duke Medical Postgraduate Course, Morehead-Biltmore Hotel, Morehead City, N. C.

July 17-19—Third Annual Dixie Postgraduate Assembly, Birmingham, Ala.

August 22-24—Sixteenth Annual Postgraduate Obstetric-Pediatric Seminar sponsored by Children's Bureau and the state health departments of Georgia, South Carolina, Mississippi, Alabama, and Florida, Riviera Beach Motel, Daytona Beach, Fla.

September 5-7—American Association of Obstetricians and Gynecologists, The Homestead, Hot Springs, Va.

September 30-October 1—Tennessee Valley Medical Assembly, Read House, Chattanooga, Tenn.

October 1962-November 1963—Fourteen Postgraduate Courses offered by the University of Tennessee College of Medicine: September 16-20—"Anesthesiology for the General Practitioner;" October (dates to be determined) — "Endocrinology — Recognition and Treatment;" October 23-25 — "Obstetrics and Gynecology;" November 6-8 — "Preoperative and Postoperative Care of the Surgical Patient."

October 6-9—Medical Society of Virginia, Roanoke Hotel, Roanoke, Va.

October 10-13—American Society of Maxillofacial Surgeons, Sheraton-Park Hotel, Washington, D. C.

October 13-18—International Congress of Plastic Surgery, Sheraton-Park Hotel, Washington, D. C.

October 14-18—Postgraduate course sponsored by the American College of Chest Physicians on Recent Advances in the Diagnosis and Treatment of Disease of the Heart and Lungs, Washington, D. C.

October 20-23—American College of Gastroenterology, Shoreham Hotel, Washington, D. C.

October 27—Association of Clinical Scientists, Statler-Hilton Hotel, Washington, D. C.

November 7-9—Conference on Obstetric, Gynecologic, and Neonatal Nursing sponsored by District Four, Washington, D. C.

November 8-9—Southern Society for Pediatric Research, St. Jude Hospital, Memphis, Tenn.

November 17-18—Twentieth Annual Meeting of The Southern Chapter of the American College of Chest Physicians, Monteleone Hotel, New Orleans, La.

November 18-21—Southern Medical Association, New Orleans, La.

December 10-12—Southern Surgical Association, The Homestead, Hot Springs, Va.

National

August 26—Annual Meeting of the American Academy of Physical Medicine and Rehabilitation, Sheraton-Dallas Hotel, Dallas, Tex.

September 15, 1963-June 15, 1964—Nine month tutorial program in Cardiology offered by the Institute for CardioPulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

September 16-28—Postgraduate course in Laryngology and Bronchoesophagology sponsored by the Department of Otolaryngology, University of Illinois College of Medicine.

October 5-11—Annual Otolaryngologic Assembly sponsored by the Department of Otolaryngology of the University of Illinois College of Medicine and the Illinois Eye and Ear Infirmary.

October 11-15, 1964—Eighth International Congress on Diseases of the Chest sponsored by the Council on International Affairs of the American College of Chest Physicians, Mexico City, Mex.

October 17-19—Clinical Neuropsychiatric Association, Sheraton-Lincoln Hotel, Houston, Tex.

October 21-22—American Cancer Society, Scientific Session, Conference on Unusual Forms and Aspects of Cancer in Man, Biltmore Hotel, New York City.

October 21-25—Postgraduate course sponsored by the American College of Physicians on Clinical Cardio-Pulmonary Physiology, Chicago, Ill.

November 11-15—Postgraduate course sponsored by the American College of Chest Physicians on Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, New York City.

November 18-20—Tenth Symposium, "Aging of the Lung: Perspectives," sponsored by the Hahnemann Medical College and Hospital, Sheraton Hotel, Philadelphia, Pa.

December 1-4—American Medical Association Clinical Meeting, Memorial Coliseum, Portland, Ore.



MULTIPLE MYELOMA

Milton H. Freedman, M.D., *Atlanta*

DUE TO IMPROVED radiographic technics, the introduction of bone marrow aspiration as a routine procedure, and more recently the application of filter paper electrophoresis to clinical studies, the diagnosis of multiple myeloma is being made with increasing frequency. Although it is not possible to ascertain whether an absolute increase in the incidence of the disease has occurred, it is certainly no longer rare. The mean annual death rate is about 9.0 per million.

A major development in the study of myeloma in recent years is that the so-called "typical" case of multiple myeloma must now be considered as representing just one of several clinical patterns that may arise from a primary dyscrasia of plasma cell origin. Cases of solitary plasmocytomas of bone, multiple plasmocytomas, extra-medullary plasmocytomas, diffuse myelomatosis, plasma cell leukemia, and most cases of so-called primary amyloidosis represent clinical and pathological variants of primary plasma cell proliferation. These several patterns overlap to a considerable extent and should be considered part of a continuous spectrum of disease, rather than a group of distinct clinical and pathological entities.

The disease appears most frequently in later life, with 80 per cent of all cases occurring after the age of forty. In all large series, a preponderance of males has been noted (approximately 60 per cent). No race or part of the world is known to be immune.

The etiology of primary plasma cell dyscrasia is still unknown. A viral etiology has been suggested, but, to date, no specific agent has been identified.

Myeloma invariably progresses to fatal termination, but the course of the disease and the rate of progression are quite variable. The average duration of life from the onset of symptoms (usually skeletal pain) is about 20 to 24 months, but survival periods in individual cases may range from a few weeks to ten or more years.

The diagnosis ultimately depends on either bone marrow aspiration or bone biopsy. It has now been established that the myeloma cell is invariably of plasma cell origin. The morphologic characteristics of myeloma cells may vary considerably, and in the same patient these cells may range from typically "mature" plasmocytes to very large and "immature" plasmoblasts. Because the distribution of lesions in myeloma is frequently patchy and irregular, the percentage of myeloma cells in marrow smears may vary from site to site and on successive sampling of the same patient. Therefore, repeated aspirations are at times necessary for cytologic documentation, and in all cases the results of bone marrow examination must be interpreted in combination with other relevant clinical and laboratory data.

As an important aid in diagnosis, paper electrophoresis of serum and urine provides a means for the detection of the characteristic protein abnormalities of multiple myeloma. When both serum and urine are examined, a significant abnormality can be demonstrated in 97 per cent of cases.

Clinical Features

Skeletal pain is the presenting symptom in the majority (approximately 90 per cent) of cases. Most cases show widely disseminated osteolytic lesions on X-ray examination, but in approximately 25 per cent of the cases, the radiographic appearance of the skeleton on initial examination is one of diffuse osteoporosis, with or without vertebral-body narrowing.

In approximately two to ten per cent of cases, the disease presents as an apparently single skeletal lesion, a "solitary" plasmocytoma. In the majority of these cases, disseminated skeletal lesions ultimately develop even if the original lesion is radically excised or adequately irradiated.

Finally, there is an important group of cases in

which the skeleton is radiographically normal at the time of initial examination. These include patients presenting with anemia, impairment of renal function (or unexplained proteinuria without renal insufficiency), symptoms specifically related to a dysproteinemia, increased susceptibility to bacterial infections, and patients whose symptoms and signs are related to paramyloid infiltrates of various organs and tissues.

Hematologic Features

Anemia, of varying severity, is present in practically all cases. Thrombocytopenia may be present along with leukopenia in about one-third of the cases before any therapy and is probably the result of bone marrow involvement.

Erythrocyte rouleau formation is demonstrable in the majority of cases of myeloma and is ascribed to the coating of the erythrocytes by the myeloma globulins. This may also account for the markedly increased sedimentation rate, the difficulty in accurate counting of red cells, and the difficulty in blood grouping and cross-matching.

The so-called plasma cell leukemia with a large number of plasma cells in the peripheral blood represents the least common clinical variant of plasma cell proliferative disease.

Protein Abnormalities and Their Effects

A disturbance of protein synthesis is usually a striking feature of multiple myeloma. This may be manifested in three forms: hyperproteinemia, Bence Jones proteinuria, and a peculiar protein deposition in the tissues, paramyloidosis.

Hyperproteinemia (in excess of eight grams per cent) occurs in 50 to 65 per cent of cases, but electrophoretically characteristic abnormal serum spikes occur in approximately 85 per cent of cases. The majority of patients exhibit a single homogeneous peak in the gamma, beta or least commonly, alpha mobility range, and rarely there may be two separate and distinct abnormal peaks of differing electrophoretic mobilities.

Approximately five per cent of myeloma globulins exhibit reversible precipitation when the serum is cooled, so-called cryoglobulins. The presence of cryoglobulins may produce various manifestations of cold intolerance: purpura after exposure to cold, Raynaud's phenomena, cold urticaria and vascular occlusion.

Impairment of blood flow may also result from the presence of abnormal serum proteins that are not cold precipitable, but which cause increased serum viscosity. These proteins are usually high molecular

weight macroglobulins, but may also be "smaller" myeloma globulins.

Bleeding manifestations may result from capillary damage due to impaired blood flow and also from interference with coagulation by the abnormal proteins in several ways: protein—protein complexing between the abnormal globulin and one or more of the clotting factors, inhibition of conversion of fibrinogen to fibrin, and increased fibrinolytic activity.

Bence Jones protein (actually a group of proteins) can be demonstrated in the urine in approximately 40 to 47 per cent of cases of myeloma. These are proteins of relatively small molecular size and difficult to identify in the serum by standard electrophoretic technics. Their concentration in the serum is usually low because of the rapid clearance rate by the kidneys. In the urine they appear as sharply defined homogeneous bands between the ranges of the alpha and gamma globulins.

Impairment

Impairment of renal function, characterized by nitrogen retention in the absence of hypertension occurs in over 50 per cent of cases of plasma cell myeloma. In many cases the renal damage can be directly related to the excretion of abnormal low molecular weight Bence Jones proteins and the damaging effect of these proteins on the renal tubules and ultimately on the entire nephron. Hypercalcemia, anemia, increased blood viscosity, infiltration with myeloma cells, and paramyloid infiltrates may also contribute to renal damage.

Atypical amyloidosis or paramyloidosis has been found in six to ten per cent of cases of myeloma. Its distribution is that of primary amyloidosis, and some investigators feel the conditions are identical. The paramyloidosis has been attributed to the production of low molecular weight proteins that are capable of diffusing through the capillary beds and binding with complementary polysaccharides to form insoluble complexes remaining in the tissues. The sites most commonly involved are the tongue, gastrointestinal tract, heart and blood vessels, the peripheral nerves and nerve roots, the skin, periarticular tissues, and carpal ligaments. Unlike secondary amyloidosis, the protein stains poorly with metachromatic dyes and has little, if any, affinity for Congo red.

Varied and Unpredictable

It is difficult to evaluate the efficacy of any particular therapeutic regimen in a disease whose course is so variable and in which the clinical patterns are so varied and unpredictable. At best, however, therapy is still poor for this disease. Irradiation is of established value in the management of localized skeletal infiltrates and large tumor masses and for relief of localized pain. In recent years urethane has

been the treatment of choice. The corticosteroids apparently may be effective in some cases. They may be given along with urethane, though frequently reserved for treatment if the patient is non-responsive or becomes refractory to urethane.

Recent reports on the use of phenylalanine mustard (sarcolysin) and chlorambucil (leukeran) have been encouraging and apparently show these drugs may be more effective than urethane in the treatment of myeloma. *340 Boulevard, N.E.*

Approved by the Professional Education Committee, Georgia Division, ACS.

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA FOR MAY, JUNE 1963

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Benton, Phillip G.	157 N. Main Street Jonesboro, Georgia	Active	Clayton-Fayette
Bowles, Francis N., Jr.	401 Peachtree Street Atlanta 8, Georgia	Active	Fulton
Brackett, Morris E.	47 Trinity Avenue Atlanta 5, Georgia	Active-A	Fulton
Eaves, Simeon G.	500 Jefferson Street Washington, Georgia	Active	Wilkes
Fletcher, Gerald F.	80 Butler Street, S.E. Atlanta, Georgia	Active	Fulton
Howell, Edgar V., Jr.	Decatur Federal Building Decatur, Georgia	Active	DeKalb
Hudgins, Herbert A.	50 Seventh Street, N.E. Atlanta 23, Georgia	Active-S	Fulton
Latham, Elizabeth B.	201 Washington St., S.W. Atlanta 3, Georgia	Active-A	Fulton
Latham, Seth E.	3390 Peachtree Road, N.E. Atlanta, Georgia	Active-A	Fulton
Lawson, Quentin T.	Valdosta, Georgia	Active	South Georgia
Lessem, Elias A.	441 West Peachtree St. Atlanta, Georgia	Active-S	Fulton
Levin, Pierre	340 Mead Road Decatur, Georgia	Active	DeKalb
Maloney, George R.	441 West Peachtree Street, N.E. Atlanta 8, Georgia	Active-S	Fulton
McGinnis, Lamar S., Jr.	Decatur Federal Building Decatur, Georgia	Active	DeKalb
Pollock, John Edward, Jr.	Gordon Street Washington, Georgia	Active	Wilkes
Reese, Louis V.	239 Auburn Avenue, N.E. Atlanta 3, Georgia	Active	Fulton
Reich, Robert A.	Decatur Federal Building Decatur, Georgia	Active	DeKalb
Scarff, Richard B., Jr.	2716 Washington Road Augusta, Georgia	Active	Richmond
Somerlot, Warren A.	35 Linden Avenue, N.E. Atlanta 8, Georgia	Active	Fulton
Stubbs, Trawick H.	47 Trinity Avenue, S.W. Atlanta 3, Georgia	Active	DeKalb
Stevens, Edward L.	829 First Street Macon, Georgia	Active	Bibb
Taylor, Claude A., Jr.	Emory University Hospital Atlanta 22, Georgia	Active	Fulton
Thompson, Hugh, Jr.	1203 Cleveland Avenue East Point, Georgia	Active	Fulton
Webb, Howard W.	80 Butler Street, S.E. Atlanta, Georgia	Active	Fulton
Yount, Charles T.	Gilbert Memorial Infirmary Athens, Georgia	Active-A	C. W. Long



CYANOSIS

Mason G. Robertson, M.D., Savannah

MEDICINE IS AN ART. We strive continually to make it a science. Bedside observations when their underlying mechanisms are unfolded, take on deeper significance. Observation itself becomes more refined.

Cyanosis is a case in point. The term, first introduced by Baumes in 1801, is derived from Greek *cyanos* meaning "blue." Other terms include *mala-die bleue* and *morbis caeruleus*. The sign was observed in chronic lung disease, congenital heart disease and in certain blood disorders such as methemoglobinemia. In 1903, Sir William Osler first described polycythemia rubra vera under the title of "Chronic Cyanosis."

Though Claude Bernard speculated in 1859 that cyanosis was due to a disturbance in blood gases, it was not until 1923 that Lundsgaard and VanSlyke first studied it scientifically. They recorded their observations in a review article in *Medicine*.

Absolute Quantity

Lundsgaard noted that cyanosis was due to the absolute quantity of reduced hemoglobin circulating in the capillary bed. He established that five grams of reduced hemoglobin per 100 cc of blood would produce a blue appearance regardless of the level of oxyhemoglobin. Color alterations due to any other cause he termed "pseudocyanosis." Examples of pseudocyanosis include argyria, due to silver deposition in the skin; blueness due to intravenous Evans blue dye (T-1824); methemoglobinemia either congenital (as in Hgb M disease) or acquired from analine dyes, acetanilid, phenacetin, nitrates, nitrites, nitroglycerin, and certain sulfa compounds; sulfhemoglobin; and carboxyhemoglobin. Methemoglobinemia gives a much more striking blue color since only 1.5 grams per 100 cc in the capillaries is necessary. Sulfhemoglobinemia is effective in only 0.5 grams per cent concentration. Carboxyhemoglobinemia from carbon monoxide poisoning gives a cherry-red appearance, not cyano-

sis, despite the marked anoxia.

It is apparent that true cyanosis is not synonymous with anoxia even when the later is present. There are four types of anoxia:: Arterial, hypokinetic, anemic, and histotoxic.

Oxygen Unsaturation

Arterial anoxia denotes oxygen unsaturation of the arterial blood. Hypokinetic anoxia refers to a greater than normal uptake of oxygen by the tissues giving a greater than normal venous oxygen unsaturation. These two types of anoxia are associated with cyanosis. Anemia, if marked, furnishes less than the required oxygen needs to the tissue. It does not cause cyanosis if less than five grams of hemoglobin per 100 cc are present. In histotoxic anoxia, the cells are blocked from taking up oxygen. The blood remains fully saturated, hence no cyanosis.

Lundsgaard elucidated the quantitative relationships in cyanosis with a simple formula. Normal hemoglobin concentration is 15 grams per 100 cc of whole blood. Three-quarters of a gram of hemoglobin takes up one volume per cent of oxygen. Normal blood, therefore, contains 20 volumes per cent when 100 per cent oxygenated. In a well person, arterial blood is slightly unsaturated by about 0.5 volumes per cent. Healthy tissues take up about five volumes per cent of oxygen. Venous blood then is normally 5.5 volumes per cent unsaturated.

Since cyanosis is manifest in capillary blood, Lundsgaard noted that the mean capillary unsaturation in volumes per cent (C) was one half the sum of the arterial (A) plus venous (B) unsaturation.

C equals $\frac{1}{2}$ (A plus B).

Normally C equals $\frac{1}{2}(0.5 + 5.5)$ or three volumes per cent. This is equivalent to 2.25 grams of reduced hemoglobin. An additional 3.7 volumes per cent unsaturation is necessary to produce cyanosis. This may occur when arterial unsaturation is increased to 4.5 volumes per cent::

$\frac{1}{2}(4.5 \text{ plus } 9.5)$ equal 7 volumes per cent.

It may also occur when the venous unsaturation is increased to 11 or 12 per cent: $\frac{1}{2}(0.5 \text{ plus } 11.5)$ equals 6 volumes per cent. Indeed, studies with venous occlusion by a tourniquet show that cyanosis develops when venous unsaturation reaches 11.5 volumes per cent.

Anoxemia

Anoxemia has been defined by pulmonary physiologists in terms of total oxygen saturation of the blood. Less than 91 per cent saturation is anoxemia. Comroe has found that the best observers can note cyanosis when saturation is 85 per cent and that some can tell it only when it has dropped to 75 per cent. A polycythemic patient with a normal oxygen saturation may nonetheless have a greater absolute concentration of reduced hemoglobin in the capillary bed. His increased hemoglobin may give him twice as much oxygen carrying capacity, but at the same time a normal degree of arterial unsaturation may give him twice the amount of reduced hemoglobin. Thus, polycythemic cardiacs may appear more cyanotic than arterial saturation studies might indicate.

Likewise, an anemic patient with only half the oxygen carrying capacity can have marked unsaturation without appearing cyanotic since the total number of reduced hemoglobin is still less than five grams per cent in the capillaries. In the days of blood-letting, the dusky-hued patient's color was thus seen to improve but his condition worsened.

Clinicians now speak of a "central" and a "peripheral" type of cyanosis. Central refers to arterial unsaturation either from decreased oxygenation in

the lung or from admixture of venous blood through a right to left shunt. The latter occurs when there is a concomitant septal defect or patent ductus associated with obstruction to normal pulmonary blood flow. These two types of central cyanosis can be differentiated when the patient breathes 100 per cent oxygen. This will improve oxygenation in the lungs but will not alter the degree of unsaturation created by a shunt. Central cyanosis may cause differential cyanosis of the lower extremities as in a pre-ductal coarctation of the aorta.

Peripheral cyanosis refers to alterations occurring after normally saturated arterial blood has reached the capillary bed. In the skin and mucous membranes, the degree of filling in the end-capillaries of the papillae and the subpapillary capillary venous plexus accounts for the visible color seen.

More Visible

Dilated capillaries obviously render the blood, whatever its color, more visible. If at the same time the flow is sluggish, or tissue O₂ uptake greater than normal, cyanosis appears greater. Carbon dioxide engorges the capillaries by arteriolar dilatation. Reduction in the CO₂ with subsequent vasoconstriction makes cyanosis less apparent. Marked vasoconstriction in shock may mask deep cyanosis.

It may be further modified by the thickness, pigmentation, and other qualities of the skin.

Cyanosis is a valuable sign when its variables are understood.

835 East 65th Street

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

NEW POLITICAL EDUCATION FILM AVAILABLE THROUGH GaMPAC

A new political education film entitled "The Barnstormer" has been produced by the American Medical Political Action Committee (AMPAC) and is now available for showing in Georgia through GAMPAC.

"The Barnstormer" is designed to instruct the amateur in the ways of political success. It does not presume the physician to be a polished political professional. It is basic, down-to-earth, precinct level politics, where all elections are won or lost.

Sophisticated Presentation

"The Barnstormer" is presented in such a sophisticated manner as to hold the complete attention of the audience from beginning to end. This film utilizes some of Hollywood's most talented writers, producers and actors.

It is an excellent, hard hitting, effective, humorous and complete political education film. It has been endorsed by the AMA and has been widely acclaimed by all who have seen it.

Civic Affairs Association, Inc. of Washington, D. C., had this to say about "The Barnstormer," "At least three qualified observers expressed the opinion that the presentation had a great deal of impact, was realistic in its approach to political effectiveness, and included originality and off-beat humor of a kind that is very effective, but generally cut out of public presentations by over-cautious management. 'Barnstormer' is one of the best presentations yet to hit the market. Don't miss it when it comes your way."



PROGRESS REPORT FROM MILLEDGEVILLE STATE HOSPITAL

I. H. MacKinnon, M.D., *Milledgeville*

A MENTAL HOSPITAL is no longer just a security area to protect the patient from himself or the safety of others. Milledgeville State Hospital must be more than a custodial institution but should be recognized as a modern hospital offering the accepted methods comparable to other accredited institutions in other states, in the administration of the best therapeutic procedures for restoring normal mental health.

Program

A good treatment program means more than new buildings and equipment. The architecture and style should be away from institutional type arrangements and should possess as much as possible a home-like atmosphere with furnishings and decor contributing to comfort and relaxation of the patient.

This setting must be endowed with personnel who are adequately trained with the best methods for promoting confidence and security resulting in an interrelationship conducive to respect and understandings. The administration of therapeutic procedures in this kind of an atmosphere results in a more effective alteration and resolution of abnormal behavior and symptomatology.

Shortages of personnel make it necessary to develop inservice training programs and to provide stipends and scholarships for specialized education in the professional and sub-professional classifications. This would apply to physicians, psychiatrists, nurses, psychologists, social and recreational workers, occupational, musical and chaplaincy therapists. In return for the training, the student is obligated to provide year for year service at the institution. This is the only successful method of obtaining satisfactory personnel in an institution located at great distances from academic centers and cities where the

labor market is unavailable. This program has been quite productive and in many areas some departments have doubled and tripled their numbers.

The hospital at Milledgeville is too large to ever be an effective means for providing care in terms of the most modern principles. New buildings which have been recently built are primarily for replacement of old wooden structures that are unsanitary and dangerous fire traps. These facilities will eliminate a 35 per cent overcrowding and will furnish day rooms and recreational areas for the comfort of the patients.

Turnover

A reduction in the 12,000 bed capacity of this institution is not anticipated in the next few years. Admissions are numbering 6,000 a year exclusive of re-admissions which average over 30 per cent of the discharges. It is apparent from these figures that Milledgeville is no longer a place of no return, which is readily demonstrated by the 50 per cent turn over. These increased admissions have required by necessity rapid discharges and increased furloughs to create beds for new acutely ill patients. This, at times, has given us some concern but this risk had to be taken, and consequently, we were agreeably surprised to find that in most instances favorable results were attained.

It is apparent that patients should be gotten out of the hospital as soon as possible and that convalescence should be at home where drugs can be administered and medical or psychiatric care provided in the clinic or doctor's office. Protracted hospitalization leads to permanency of and production of chronic mental illness. It has been demonstrated that about 75 per cent of most new admis-

sions should be released from the hospital within 30 to 90 days.

Discussion of Causes

There has been much discussion relative to the causes for the increases in the admission of psychiatric cases to hospitals. There are several factors responsible for this condition. First, one must consider the increase in the population, as well as the extended life cycle of its members. Secondly, the public has become more mental health minded through information provided by news media, radio and television, and the subject has been more accepted by the Medical Profession. Thirdly, more facilities in general hospitals and out-patient clinics, with increasing numbers of psychiatrists, have made available resources previously unknown. But last and most important has been the change in commitment laws which have removed the stigma that formerly made patients reluctant to seek assistance in the early stages of their illness. We are seeing in Milledgeville an entirely different variety of patients that formerly would not consider accepting help in a state mental hospital. With the removal of psychiatric resistance and the early recognition and treatment of mental symptoms it would be natural that shorter periods of hospitalization and rapid recoveries would be expected.

Enlarged Area

Psychiatry today is spreading out over many areas that formerly would have never been included. For example, the emotional disturbances in children, the adolescent problems and delinquency, the alcoholic and drug cases, forensic psychiatry, geriatrics, vocational and marital counseling are a few of the areas that are receiving considerable attention and are demanding psychiatric services in our hospitals.

It is necessary to provide special wards of buildings for these different categories, as each type requires a kind of treatment suitable for each variety of disorder. This means we have wards for alcoholics, with special medical facilities and psychiatric supervision. Also children and adolescents need separate buildings with included school and educational facilities. This will be available within a year when new buildings especially designed for these cases will be completed.

We have about 3,000 geriatric cases in our hospital and we are screening these senior citizens for placement in nursing and foster homes. As a result, some are being returned to their homes, after many years of hospitalization. We anticipate reducing the number of geriatric cases by several hundred in the coming fiscal year, as well as making arrangements for new admissions to be relocated as quickly as possible. These procedures will probably cut down

the size of Milledgeville faster than any other method and have been quite successful in other states.

Much emphasis has been placed on the physical aspect of our mental cases. Patients who are blind with cataracts or have hearing difficulties do not possess the sensory contacts essential to proper relationships. Diabetes, cardiovascular, anemias, and other constitutional diseases must be given the proper attention to remove toxic complications that impair the chances for the alleviation of the psychiatric disorder.

Modern Facilities

Milledgeville has a 300 bed general hospital, with all modern facilities, and a staff of specialists in all areas of medicine and surgery who are providing services on a full time basis to all of our patients. This has been accomplished by dividing the hospital into seven units, which are separate or miniature hospitals within themselves. Each unit has its own complete staff admission and intensive treatment unit. There is also provided a small infirmary, to take care of the mild physical problems, which is supervised by a general medical man, who belongs to the unit on a full time basis, but is under the direction of the director of the medical and surgical unit. This physician is also responsible for the physical and neurological examination of each patient, which provides the psychiatrist with more time for the application of other therapeutic procedures. Each unit has its own director, business administrator, nursing supervisor, psychologist, social worker, chaplain, rehabilitation officer, recreational and occupational therapist, and team of psychiatrists. This makes each unit a teaching, training, and intensive treatment center, in which all personnel participate, and the entire hospital becomes an active contributor to an overall educational and therapeutic program, which has improved the morale and cooperation and is reflected in the good results being obtained.

Research

Research is the answer to the detection of the causes, approaches and techniques for understanding, preventing, and improving treatment in a mental hospital. We have organized a new department, in its own separate building, staffed with a neuropharmacologist, neurophysiologist, neurochemist, medical geneticist, and a corps of trained laboratory technicians. Projects are now under investigation and plans are in operation for further expansion of personnel and the addition of research equipment to meet the needs for solving some of the many problems in the field of mental disease.

There have been many additions to our psychiatric staff of the hospital, in which area we have had difficulty in finding experienced physicians desirous

MENTAL HEALTH PAGE / Continued

of doing institutional assignments. There are not only shortages, but considerable competition for these specialists, who prefer to be near cities and educational centers. However, we have instituted a residency training program, with affiliation at Emory and the Medical College of Georgia psychiatric departments, which is training this fiscal year about 18 doctors in this specialty. It will take another year before these men will start to become available for assignments at Milledgeville, but we are looking forward with high hopes to the marked improvement in this important area.

Follow-up

We are also developing a better follow-up system of our discharged cases, so that they can be kept out of the hospitals. We are in the process of organizing

Prepared at the request of the Sub-committee on Mental Health of the Medical Association of Georgia.

A NEW MODEL — MAG ANNUAL SESSION 1964

Plans are set for a streamlined 1964 Annual Session of the Medical Association of Georgia. The state medical association meeting will be held at the air-conditioned Auditorium in Macon, Georgia, on May 3-6, 1964. Bibb County Medical Society will act as host to physicians from all over the state at this meeting.

New Exhibits Floor Plan

Commercial and scientific exhibits will be displayed in the Auditorium in a new "free style" manner. This will eliminate the narrow aisles and exhibit rows and forced traffic patterns in gaining entrance and exit from the scientific session meeting rooms.

Scientific Section Meetings Organized

To prevent numerous conflicts in having too many sections at the same time, a simplified system of MAG Section meetings has been scheduled. It is believed that this will provide for greater attendance at each meeting, rather than spreading this same attendance thinly over five or six meetings concurrently. The scientific section meeting scheduled is:

Sunday Afternoon, May 3 at 3:00 p.m. to 5:30 p.m.

- (1) Pediatrics, Psychiatry, Dermatology and Public Health Joint Section Meeting (Main Meeting Room, Auditorium)
- (2) Radiology, Chest, and Orthopedics Joint Section Meeting (Kilowatt Room, Georgia Power Bldg.)

Monday Morning, May 4 at 10:00 a.m. to 12:00 noon

- (1) Diabetes, Medicine, Pathology and Surgery Joint Section Meeting (Main Meeting Room, Auditorium)
- (2) Anesthesiology, and Obstetrics and Gynecology Joint Section Meeting (Kilowatt Room, Georgia Power Bldg.)
- (3) Urology, EENT and Public Health Joint Section Meeting (Civic Room, Auditorium)

Tuesday Morning, May 5 at 9:00 a.m. to 11:00 a.m.

and developing these facilities, as well as many other projects which will provide proper psychiatric care, comparable to the best accepted medical standards. Patients on furlough may return to the psychiatric clinic at the hospital for renewed medication and psychotherapy. We believe that this clinic will provide the additional support for maintaining the patient in an adjustment in his home environment, and prevent the numerous re-admissions to the hospital.

This report can only provide a superficial review of the progress that has been accomplished in the last three years, and will provide the medical profession with information relative to what is being done in a general way for a better organization and administration of the psychiatric facilities of the Milledgeville State Hospital.

Milledgeville State Hospital

- (1) G.P. Day Meeting (General Session) Main Meeting Room, Auditorium

Tuesday Afternoon, May 5 at 2:30 p.m. to 5:00 p.m.

- (1) Medicine and Pathology Joint Section Meeting (Kilowatt Room, Georgia Power Bldg.)
- (2) Diabetes, Surgery, and Obstetrics and Gynecology Joint Section Meeting (Main Meeting Room, Auditorium)

General Session Scheduled

The three Association General Sessions, to which all members are invited, are set as follows: (1) Sunday, May 3 at 2:00 p.m. to 3:00 p.m. for the purpose of nominations to MAG office and the traditional MAG memorial service; (2) Monday, May 4 at 12:00 noon to 1:00 p.m. for the purpose of hearing addresses from the MAG out-going and incoming Presidents; and (3) Wednesday, May 6 at 10:30 a.m. to 11:30 a.m. for the purpose of presenting awards, election results and installation of officers.

Delegates Meeting Rescheduled

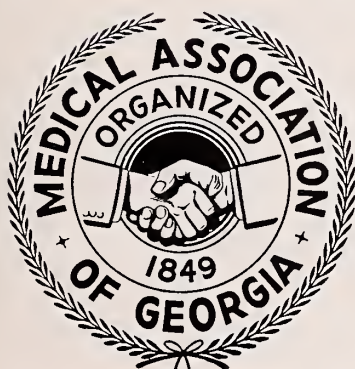
The first session of the MAG House of Delegates, at which time all business before the House is introduced, has been rescheduled to meet Monday morning, May 4 at 9:00 a.m. to 10:00 a.m. All five Reference Committees will then meet that same afternoon in the Auditorium on Monday, May 4 at 2:30 p.m. The House will reconvene for its Reference Committee reports and final voting actions on Wednesday morning, May 6 at 9:00 a.m. to 10:30 a.m.

Specialty Society Meetings and Socials

Sunday evening, May 3; Monday noon and afternoon, May 4; and Tuesday noon, May 5 have been given over to specialty societies for scheduling their own luncheons, dinners and scientific sessions. Of special interest is that Monday afternoon, May 4 has been designated as an "open afternoon" so that specialty societies desiring actual business or scientific meetings may convene at that time.

1964 Annual Session

May 3-6, 1964—Macon, Georgia



First Call for Scientific Papers

All titles must be submitted to the
respective program chairmen listed
below before November 1, 1963

ANESTHESIOLOGY

Earl Avant, M.D.
781 Spring Street
Macon

CHEST

Sam E. Patton, M.D.
797 Poplar Street
Macon

DERMATOLOGY

Richard B. Ewing, M.D.
643 Orange Street
Macon

DIABETES

H. C. Atkinson, M.D.
724 Hemlock Street
Macon

GENERAL PRACTICE

Charles E. Bohler, M.D.
Box 8
Brooklet

HEART

Thomas L. Ross, M.D.
700 Sping Street
Macon

MEDICINE

Henry H. Tift, M.D.
765 Spring Street
Macon

OBSTETRICS AND GYNECOLOGY

Gordon W. Jackson, M.D.
740 Hemlock Street
Macon

OPHTHALMOLOGY AND OTOLARYNGOLOGY

W. D. Jarrat, M.D.
629 First Street
Macon

ORTHOPEDICS

L. Clyde Sheehan, Jr., M.D.
671 Hemlock Street
Macon

PATHOLOGY

Leonard Campbell, M.D.
548 First Street
Macon

PEDIATRICS

John Paul Jones, M.D.
885 Pine Street
Macon

PSYCHIATRY

Thomas M. Hall, M.D.
752 Hemlock Street
Macon

PUBLIC HEALTH

Robert J. Walker, M.D.
Macon-Bibb County Health Dept.
Macon

RADIOLOGY

Robert F. Cato
722 First Street
Macon

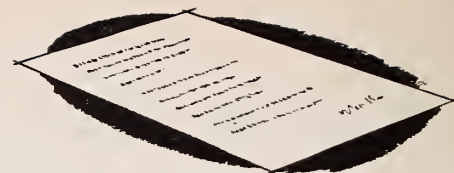
SURGERY

J. P. Woodhall, M.D.
724 Hemlock Street
Macon

UROLOGY

Robert W. McAllister
811 Orange Terrace
Macon

ABSTRACTS BY GEORGIA AUTHORS



Azar, Gordon J., M.D., 1302 Biltmore Drive N.E., Atlanta, Georgia, "Acute Nonspecific Pericarditis Complicated by the Development of Constrictive Pericarditis," *Am. Heart J.* 65:474-481 (April) 63.

There is the popularly held opinion that constrictive pericarditis is rarely, if ever, a sequel of non-specific pericarditis. There have been many follow-up series of acute non-specific pericarditis with no cases of chronic constrictive pericarditis being found as sequelae.

On the other hand, studies of patients with constrictive pericarditis reveal a large percentage of cases of unknown etiology. This has suggested the possibility that some of these cases may have followed acute non-specific pericarditis.

Two cases are presented in which acute non-specific pericarditis was complicated by the development of constrictive pericarditis at approximately eight and six and one half weeks with pericardiectomy at 13 and ten and one half weeks respectively.

There are nine previous cases mentioned in the literature. Only four of these are actually reported cases.

In the 11 cited cases, constriction occurred within six months in six cases and after four years in four cases. The earliest occurrence of constriction was at six and one half weeks, and the longest occurrence was at six years.

Thoroughman, James C., M.D.; Simon Krantz, M.D.; Joseph Mendeloff, M.D.; and William C. Wansker, M.D., 4150 Peachtree Road, N.E., Atlanta 19, Georgia, "Five-year Survival Without Symptoms of Superior Sulcus Tumor," *Dis. Chest* 43:324-323 (March) 63.

Since five year survival of patients with superior sulcus malignancy has been so rarely noted in the literature, it seems worthwhile to report a patient who is well and without evidence of recurrent disease or metastases six years after operation and roentgen therapy.

W. B. H., a 33 year old white postmaster, in 1956 noted pain in the right shoulder radiating down the right arm and into the hand, associated with increased difficulty in writing. Roentgen films of the chest revealed an abnormal mass in the right apex measuring approximately six centimeters in diameter. He was referred to the Atlanta Veterans Administration Hospital for treatment. Except for the chest findings, slight shoulder girdle atrophy, and weakness of the intrinsic muscles of the hand, physical and laboratory examinations were within normal limits.

Thoracotomy was performed with removal of a portion of the first, second and third ribs, together with a tumor of the thoracic inlet invading the pleura. The brachial plexus and the subclavian vessels were closely ap-

proximated but not involved by the tumor. Convalescence was uneventful. Roentgen therapy was given post-operatively. The pathology was a malignant neoplasm-type unclassified. The patient has remained well.

Gramling, Z. W., M.D., and Perry P. Volpito, M.D., Talmadge Memorial Hospital, Augusta, Georgia, "Flammability of Fluoromar in the Circle Absorption System," *Anesthesiol.* 24:194-197 (Mar.-April) 63.

Fluoromar with oxygen in a closed circle absorption system was employed as the anesthetic agent for 27 patients. Concentrations of Fluoromar in the anesthetic circuit were determined at frequent intervals throughout anesthesia by means of gas chromatography. Random samples of the anesthetic mixture were exposed to both an open flame and to a high frequency spark. Fluoromar concentrations above 4.4 per cent both burned and exploded. Serial determinations made during anesthesia frequently showed concentrations above the lower flammable limit. These results indicate that a closed circle-absorption system utilizing Fluoromar as the anesthetic agent should be considered a flammable technique.

Achord, James L., M.D., and Herbert D. Proctor, M.D., 69 Butler Street, S.E., Atlanta 3, Georgia, "Malignant Degeneration and Metastasis in Peutz-Jeghers Syndrome," *Arch. Int. Med.* 111:498-502 (April) 63.

Hereditary mucocutaneous pigmentation and small bowel polyposis was originally described as malignant in 20 per cent or more of the cases. More recently, however, serious doubt has been raised as to whether these polyps ever become malignant. The authors reviewed the world's English language literature and failed to find a single well-documented case of metastasis or a death directly attributable to malignancy developing in such a polyp. The patient presented, however, was a 13 year old Negro female with the typical features of the syndrome. She had the often seen gastric polyps as well as small bowel polyps and presented with gastrointestinal bleeding. She then developed jaundice, a very large liver and ascites. Post-mortem examination revealed a malignancy in a large gastric polyp with local extension, invasion of the diaphragm and metastasis to the liver. The authors feel that malignant potential may exist in Peutz-Jeghers syndrome, but manifests itself as metastasis only in rare instances. The more common but still unusual occurrence is local malignant extension. The frequency of malignant degeneration is probably less than three per cent. Radical surgical procedures are not recommended in the usual case of Peutz-Jeghers syndrome.

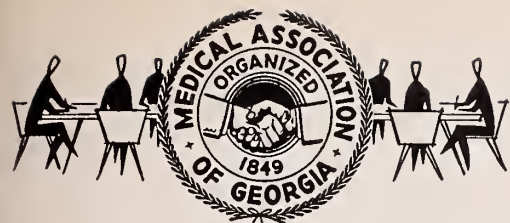
Kite, J. Hiram, M.D., 490 Peachtree Road, N.E., Atlanta 8, Georgia, "Some Suggestions on the Treatment of Club Foot by Casts," *J. Bone & Joint Surgery* 45:406-412 (March) 63.

This paper was an Instructional Course Lecture given at the annual meeting of the American Academy of Orthopedic Surgeons. The thesis was the recommendation that congenital club feet be treated by a series of plaster casts and without the use of forcible manipulations under anesthesia, and without any form of operation. The favorite treatment everywhere has been a few weeks in casts, and then forcible manipulations, tenotomies, tendon transfers, releases, enucleations, wedge resections, and triple arthrodesis. All of these operations leave scars and add permanent stiffness to the feet. It is recommended that the clubfoot deformity be gently corrected by a series of casts applied every week or two. This non-operative method gives not only better appearing feet, but feet which are more nearly normal functionally. The details used in the cast treatment are described. More than 900 clubfooted patients have been corrected by this method without resorting to operation.

Zuspan, Frederick P., M.D., and Eduardo Talledo, M.D., Medical College of Georgia, Augusta, Georgia, "A Chemical Tourniquet for Vaginal Surgery," *South. M.J.* 56:394-398 (April) 63.

Vasoconstrictors (pituitrin, epinephrine, phenylephrine) were injected locally in patients undergoing vaginal surgery to decrease blood loss and transfusion risks.

One hundred twenty-one patients were studied and divided into two groups, infiltrated (50) and non-infiltrated (71). Surgical procedures performed were vaginal hysterectomy, with anterior repair and vaginal hysterectomy with anterior and posterior repair. Only the groups treated with vaginal hysterectomy with anterior and posterior repair were considered for statistical analysis. The mean blood loss in the non-infiltrated group (45 patients) was 660 cc. The mean blood loss in the infiltrated group (40 patients) was 395 cc. The difference was statistically significant with a p-value (0.006). Of the infiltrated group, 24 per cent required blood transfusions as compared to 71 per cent in the non-infiltrated group. There was one cardiac arrest in the infiltrated group, thought to be due to anoxia. The patient made a successful recovery. There was one death in the non-infiltrated group due to transfusion with incompatible blood. It appears that hemostatic solutions are helpful in decreasing the amount of blood loss in vaginal surgery.



THE ASSOCIATION

DEATHS

HERBERT J. ROSENBERG, 77, of Atlanta and Montgomery, Alabama, a retired Atlanta physician, died in Montgomery, May 31, 1963.

Dr. Rosenberg practiced medicine in Atlanta for 52 years and delivered three generations of Atlantans. He served 25 years on the staff of Grady Memorial Hospital.

Dr. Rosenberg was a native of Charleston, S. C., and graduated from the University of Maryland.

Survivors include a daughter, Mrs. Herman Loeb of Montgomery; sons, Herbert J. Rosenberg, Jr., and Le-man L. Rosenberg, both of Atlanta; a sister, Evelyn Rosenberg of Greenwood, S. C., and brothers, Marion L. Rosenberg of Atlanta and Col. Ernest R. Rosenberg of Greenwood.

Final rites were held June 10, 1963, in Thomaston for **JOHN A. THURSTON**, 70 year old Veterans Administration career doctor. Dr. Thurston, who made his home in Atlanta, died June 8, 1963, at St. Joseph's Infirmary after undergoing surgery following a brief illness.

Dr. Thurston had served as chief surgeon at Veteran's Hospitals in Washington, D. C., Dublin and Atlanta. Prior to his recent retirement he was assistant to the chief medical officer of the Veterans Administration in Atlanta.

He was a member of the First Baptist Church of Dublin, a Mason, member of the Ansley Country Club, the Fulton County Medical Society and the American College of Surgeons.

Survivors include his wife, the former Sallie Houston; one brother, Victor G. Thurston, Thomaston; two nieces, Mrs. J. W. Cooper, Columbus, and Mrs. E. Gantt Williams, Macon.

WILLIAM EDGAR MAYHER, JR., 60, Columbus surgeon, died May 25, 1963, at St. Francis Hospital after having suffered a heart attack.

Dr. Mayher, born in Sulphur Springs, Texas, had practiced medicine in Columbus since 1929.

Dr. Mayher attended the University of Arkansas School of Medicine, Ouachita College, and the University of Southern California.

He was recently elected president of the Columbus Area Health Planning Council.

He was a past president of the Muscogee County Medical Society and was formerly Muscogee County Health officer.

Dr. Mayher was a Fellow in the American College of Surgeons, and a member of the Medical Association of Georgia. He was a member of Trinity Episcopal Church.

Other clubs and organizations of which he was a member were the Executives Club, Country Club, Big Eddy Club, and Shriners. He was a former member of the Kiwanis Club.

He is survived by his wife, Frances Lummus Mayher; a son, William E. Mayher, III, a student at the Medical College of Georgia; a daughter, Frances Lummus Mayher; his father, William E. Mayher, Sr.; and a sister, Mrs. Margaret Mayher Sutherland, all of Columbus.

SOCIETIES

The doctor in politics was the topic of discussion at the May 13, 1963, meeting of the **CARROLL-DOUGLAS-HARALSON COUNTY MEDICAL SOCIETY** held in Carrollton. Dr. John T. Mauldin, Secretary of the Medical Association of Georgia, and Mr. Jim Moffett, Assistant Executive Secretary of the Association, presented talks on the subject. A film, relating to the doctor in politics and in the community, entitled, "Operation Hometown," was shown to emphasize the topic.

Albany neuro-surgeon, William D. Lowery, Jr., spoke on, "Recent Advances in Diagnosis and Treatment of Brain Tumor," at the June 6, 1963, meeting of the **WARE COUNTY MEDICAL SOCIETY**.

For the second consecutive year, the **WHITFIELD COUNTY MEDICAL SOCIETY** is sponsoring the Suitcase Baseball League at the Community Recreation Center in Dalton.

The Suitcase League, for boys eight to 12 years of age is part of the recreation program conducted by the Community Center. The Medical society donated \$300 for the operation of the league this summer. This donation furnishes the league with umpires, scorers, uniforms, bats, balls and other needed equipment. In the two years of sponsorship, the medical society has furnished the league with \$675.

PERSONALS

First District

The Chatham-Savannah Tuberculosis Association recently sponsored a month long information campaign on respiratory diseases. **J. MOULTRIE LEE** is president of the association and **BERNARD M. PORTMAN** served as campaign chairman.

JOHN ELL HENDLEY, formerly of Sylvania, has recently moved into the clinic which had been occupied by **JOHN R. HARRISON** of Millen. Dr. Harrison and his family have moved to Chamblee.

Second District

JACOB H. HOLLEY is now associated with **ROBERT J. STARLING** at the Moseley Clinic and Hospital in Donaldsonville.

The new director of public health for the Thomas-Grady-Brooks County district, **JOE I. PALMER**, Thomasville, recently began the local phase of his indoctrination period after completing a three months

THE ASSOCIATION / Continued

period working with various state institutions. Dr. Palmer succeeded the late JOHN D. STILLWELL, and began his duties June 1, 1963.

J. KENNETH EAKINS of Thomasville has announced plans to give up his pediatric practice, possibly within a year, to enter the ministry. Dr. Eakins hopes to attend a seminary in the Southern Baptist Convention.

Memorial Hospital of Bainbridge now has the services of a full time Radiologist, R. F. DICKINSON, formerly of New Orleans. Dr. Dickinson began his assignment June 4. Previously the hospital had had radiologic services one day weekly.

Third District

No news submitted.

Fourth District

No news submitted.

Fifth District

The Ponce de Leon Infirmary of Atlanta has announced the association of JOHN A. TUCKER, formerly of Johns Hopkins, the University of Pennsylvania and Valley Forge Hospital. Dr. Tucker's specialty is ORL.

J. HIRAM KITE, Atlanta, Surgeon-in-Chief for the Scottish Rite Hospital for Crippled Children, received an honorary Doctor of Laws degree at Randolph-Macon College, June 2, 1963.

A recent guest lecturer at the Macon General Hospital was BRUCE LOGUE of Atlanta. Dr. Logue's talk was entitled, "Present Status of Anticoagulant Therapy."

JOHN E. STEINHAUS, Atlanta, President of the Southern Society of Anesthesiologists and recently re-elected delegate for the Georgia Society of Anesthesiologists Conference, served as associate examiner for the American Board of Anesthesiology in Phoenix, Arizona, April 22-26, 1963.

Sixth District

No news submitted.

EXECUTIVE COMMITTEE OF COUNCIL MEETING

THE JUNE EXECUTIVE Committee of Council meeting was called to order at 9:03 a.m., June 8, 1963, at the Holiday Inn, Callaway Gardens, Pine Mountain, Georgia, by the Chairman, President George R. Dillinger.

The members in attendance were: George R. Dillinger, Thomasville; Thomas W. Goodwin, Augusta; Virgil Williams, Griffin; Walker Curtis, College Park; John T. Mauldin, Atlanta; J. G. McDaniel, Atlanta; and Addison W. Simpson, Washington. MAG Staff members present were: Mr. Milton D. Krueger, Mr. James M. Moffett and Mrs. Catherine Wooten.

Reading of Minutes

Mr. Krueger read the minutes of the May Executive Committee meeting and on motion duly made and seconded they were approved as read.

Treasurer's Report

Mr. Krueger gave the Treasurer's Report in the absence of Dr. Atwater. The report was approved as presented.

Seventh District

Elected as Historian for the American College of Chest Physicians at the recent 29th Annual Meeting held in Atlantic City, June 13-17, was CARL C. AVEN of Marietta.

DAVID M. NOWELL, Dalton, President of the medical staff of Hamilton Memorial Hospital, has recently successfully passed all examinations for certification by the American Board of Obstetrics and Gynecology.

Appointed early in June as Chief of Staff and Secretary, respectively, of the new Northwest Georgia Medical Care Unit, Fort Oglethorpe, were FRED H. SIMONTON of Chickamauga, and GEORGE VASSEY, Rossville.

Other members of the medical care unit staff are T. E. ADKINS, L. L. ALEXANDER, T. W. ALBROOK, C. ROBERT CLARK, T. A. COCHRAN, W. D. CRAWLEY, T. H. CURTIS, H. C. DERRICK, JOHN C. ELLIS, SARA L. GOOLSBY, EDWARD G. JOHNSON, ROBERT T. JONES, G. E. KINARD, FRANK L. O'CONNER, ROY POPE, JR., LEROY SHERRILL, J. P. SIMS, F. JONES SMILEY, CHARLES W. STEPHENSON, ODOM F. VAN WERSSOWETZ and L. A. WILLIAMS.

Recently named as the Vice-president of the Georgia State Obstetrical and Gynecological Society was W. STEVE WORTHY of Carrollton.

DONALD R. ROONEY, Marietta, spoke June 6, 1963, to the Marietta Kiwanians on the subject, "The Medical Profession's Approach to the Financing of Medical Care of the Aged."

Eighth District

G. W. BARKER and REX STUBBS announced that, as of July 1, 1963, RAY HAMPTON will be associated with them at the St. Mary's Clinic, St. Mary's.

Ninth District

No news submitted.

Tenth District

No news submitted.

Talmadge Hospital Liaison Committee Activity and Appointment of Chairman

Dr. Dillinger gave background information regarding the function of the Talmadge Hospital Liaison Committee. After discussion about the inactivity of this committee it was suggested that a letter be written to the Chairman of the Committee, Dr. C. H. Richardson, Sr., Macon. On motion (Mauldin-McDaniel) it was voted to ask the President to write the committee chairman and request that a meeting be held at least twice a year, with one meeting scheduled at the time of the MAG Annual Session, and that a letter be written to the President of the Medical College of Georgia and the President of the Richmond County Medical Society.

Legal Fees Data

Dr. McDaniel stated that the MAG Attorneys desired to increase their retainer fee. After discussion it was suggested that a committee composed of Dr. McDaniel and Dr. Mauldin negotiate with the attorneys and report back to the Executive Committee in July. Dr. McDaniel stated that he would inform Council that the attorneys had requested an increase in the retainer fee, that the Executive Committee is considering the matter, and will present this matter at the September Council Meeting.

MAG Employees Pension Plan

Dr. McDaniel stated that a Retirement Plan for the employees of MAG and a Trust Agreement creating a Trust under which the Plan would be administered by the Fulton National Bank as Trustee, had been worked out. On motion duly made and seconded it was voted to receive this for information, as the Retirement Plan will be presented to Council on this date.

Georgia Plan Clarification

Dr. Mauldin stated that two letters had been received from insurance companies requesting clarification concerning payment of benefits to certain practitioners; (1) Georgia Life and Health Insurance Company: After reading this letter to the Executive Committee, on motion duly made and seconded it was voted to ask the Secretary to write a letter to the company answering their questions; (2) American Mutual Liability Insurance Company: After reading this letter, on motion it was voted to ask the Secretary to call Dr. David R. Thomas regarding disposition and report back to the Executive Committee.

State Board of Health Appointments

The suggested appointments from the Second and Ninth District were read to the Executive Committee and discussed. The First District had not reported. Therefore, it was suggested that this item be placed on the Council agenda for discussion.

MAG Board and Subcommittee Appointments

The Executive Committee reviewed the Boards and Subcommittees and made the necessary recommended appointments per the attached list.

In connection with the above appointments Dr. Morris Brackett was appointed a full member of the Maternal and Infant Welfare Subcommittee. Dr. James N. Brawner's membership on Mr. James Bentley's Insurance Committee for the purpose of reviewing the question of insurance coverage for mental illness was approved.

Headquarters Office Report

Mr. Krueger gave a report on the following items: (1) *Cornell Study*: Executive Committee approved the study of recent model passenger cars in injury producing accidents; (2) *MAG Headquarters Staff Work*: Saturday work for secretarial employees was deferred until the July Executive Committee meeting; (3) *Stover Commission on Podiatry*: It was suggested that the MAG representatives who will attend the AMA meeting in Atlantic City contact Dr. Stover, Chairman of the AMA Commission which is studying podiatry, and discuss the progress of his commission in this regard; (4) *Georgia Society of Association Executives*: Mr. Moffett asked for approval of membership in the Georgia Executives Association and payment of dues in the amount of \$18.75. This was referred to Council.

New Business

(1) The matter of the State Board of Health letter regarding relationship between the Board of Health and the Medical Association of Georgia was discussed. This was received for information. (2) Date and Site of July Executive Committee meeting: July 17, 1963, 4:30 p.m., MAG Headquarters Building

There being no further business the meeting was adjourned at 1:05 p.m.

MAG COUNCIL MEETING

THE QUARTERLY MEETING of the Council of the Medical Association of Georgia was called to order at 2:10 p.m., June 8, 1963, Holiday Inn, Callaway Gardens, Pine Mountain, Georgia, by the Chairman, Dr. Addison W. Simpson.

Council members attending this meeting were: Addison W. Simpson, Washington; George R. Dillinger, Thomasville; J. G. McDaniel, Atlanta; Thomas W. Goodwin, Augusta; Walker L. Curtis, College Park; John Kirk Train, Savannah; John T. Mauldin, Atlanta; J. Frank Walker, Atlanta; Charles E. Bohler, Brooklet; W. Frank McKemie, Albany; Frank A. Wilson, Leslie; Virgil B. Williams, Griffin; Floyd Sanders, Decatur; William Rawlings, Sandersville; Ralph N. Johnson, Rome; F. G. Eldridge, Valdosta; C. R. Andrews, Canton; J. C. Brim, Pelham; Robert Martin, Cuthbert; C. T. Cowart, LaGrange; W. C. Mitchell, Smyrna; J. W. Yeomans, Jesup; Walter Brown, Savannah; H. D. Pinson, Augusta; Luther H. Wolff, Columbus; George H. Alexander, Forsyth; Charles S. Jones, Atlanta; J. L. Mulherin, Augusta; Linton H. Bishop, Atlanta; J. W. Chambers, LaGrange;

Eustace A. Allen, Atlanta; P. D. Ellington, Augusta; Edgar Woody, Jr., Atlanta. Mr. Frank Shackelford, MAG Attorney, was present at this meeting, as well as MAG Staff members: Mr. Milton D. Krueger, Mr. James M. Moffett and Mrs. Catherine Wooten.

Dr. Goodwin was called upon to give the invocation.

Chairman Simpson made introductory remarks as this was his first meeting as Chairman of Council.

Reading of Minutes

Mr. Krueger reviewed the minutes of the previous Council meeting and the Executive Committee meeting in May. These minutes were approved as read.

Treasurer's Report

Mr. Krueger gave the Treasurer's report in the absence of Dr. Atwater. On motion (Brown-Johnson) it was voted to accept the Treasurer's report as presented.

MAG Employees Pension Plan

Dr. McDaniel and Mr. Shackelford discussed the Pension Plan and Mr. Shackelford presented a Resolution for consideration of Council to be adopted in connection with the plan as follows:

RESOLUTION

WHEREAS, there have been presented to the meeting a retirement plan for the employees of the Association and a Trust Agreement creating a Trust under which the Plan will be administered by the Fulton National Bank as Trustees; and

WHEREAS, after full discussion, adoption and execution of the same appear to be in the best interest of the Association.

NOW, THEREFORE, IT IS HEREBY RESOLVED, that the Retirement Plan and Trust Agreement presented to the meeting be and they are hereby adopted and approved by this Council, and the President of the Association is hereby authorized and directed to execute the Plan and Trust Agreement on behalf of the Association, and the Secretary is hereby authorized and directed to attest the same in the form attached to these Minutes or as changed upon direction of the Executive Committee of Council after suggestions received from the Trustee, the Office for Dependents' Medical Care, and any other government agency which will reimburse the Association for a portion of the cost of said Retirement Plan, and the Secretary is directed to certify copies, thereof and of this resolution to the said Trustee and the Director of Internal Revenue; and

RESOLVED FURTHER, that the signatures of the President and Secretary on said Plan and Trust Agreement as aforesaid shall be conclusive evidence that the Plan and Trust so executed are the same approved and adopted by this Council; and

RESOLVED FURTHER, that the President and Secretary are hereby authorized and directed to execute any and all further amendments to the said Plan and Trust Agreement which may be required to qualify the same in the opinion of the Director of Internal Revenue; and

RESOLVED FURTHER, that the officers be and they are hereby directed to pay to said Trustee the sum of \$1,000.00 immediately to be credited against the total contribution of \$3,422.00 for the calendar year of the Association ending December 31, 1963, as required under said Plan; and

RESOLVED FURTHER, that copies of the Plan and Trust Agreement be attached to and made a part of the Minutes of this meeting.

On motion (McDaniel-Goodwin) it was voted to accept the Retirement Plan as described in the above Resolution, and to pay the \$1,000.00 to the Trustee immediately, to be credited against the total contribution of \$3,422.00 for the calendar year of the Association ending December 31, 1963, as required under the Plan. The \$1,000 to be paid from the Contingent Fund. An outline of the Plan is attached to these minutes.

Confirmation of Executive Committee Board and Subcommittee Recommended Appointments

Dr. Dillinger asked that the recommended list of appointments be read to Council. After reading this list on motion (Goodwin-Williams) it was voted to accept the recommendations of the Executive Committee.

THE ASSOCIATION / Continued

Podiatry Resolution

Dr. Mauldin stated that the House of Delegates action on Podiatry had been to refer it to Council for further study of and prompt transfer of Council's recommendations to the Legislative Board. After discussion it was voted, on a motion by Dr. Wolff and seconded by Dr. Pinson, to instruct the AMA delegates to support the Wisconsin Resolution submitted to the AMA House of Delegates in June, 1961. With regard to state legislation, it was suggested that Council consider this at the September meeting before the 1964 State Legislature convenes.

Muscogee County Medical Society Councilors

Mr. Krueger stated that Muscogee County Medical Society Councilor W. P. Jordan had resigned and Dr. Luther Wolff was appointed to fill Dr. Jordan's unexpired term. Then a new Vice-Councilor was elected. According to the MAG Constitution and Bylaws the new Vice-Councilor was in fact a nominee until the next MAG Annual Session, at which time he will be installed.

Revision of Annual Session Program

Dr. Dillinger presented a proposed plan for the Annual Session program. On motion (Wolff-Jones) it was voted that the President's proposal be studied by the Annual Session Board, the President, and the Speaker of the House, with a report to be made to the Executive Committee at the July meeting, and that the Executive Committee be empowered to act in the decision for the program at the 1964 Annual Session meeting.

Professional Conduct Committee Report

Mr. Moffett reported on a case before the Professional Conduct Committee. He had been asked to obtain approval of Council to send a letter drafted by the Chairman of this committee to the complainant. On motion (Jones-Williams) it was voted to approve the letter as written and to send it to the complainant.

Reorganization of District Medical Societies and Inactive County Medical Societies

Dr. Goodwin discussed the problems involved and asked Council to think about them and make any suggestions. On motion (Wolff-Brown) it was voted to ask the President to appoint a special committee to be headed by Dr. Goodwin to make recommendations to Council.

Mental Health Subcommittee Recommendations

Dr. Mauldin read the Mental Health Subcommittee recommendations which had been referred back to Council from the House of Delegates. After discussion on motion (Mauldin-McDaniel) it was voted to refer these recommendations back to the Mental Health Subcommittee with the request that the committee establish priorities on the items listed, make recommendations, and report back to the Executive Committee.

Old Business

Dr. Cowart made a progress report on the study being made by the Georgia Hospital Medical Council of the relationship between radiologists and hospitals. He stated that legal consultation would be necessary and asked MAG participation in the payment of this legal consultation. On motion (Mauldin-Sanders) it was voted that MAG endorse in principle the need for legal consultation for the Georgia Hospital-Medical Council, in the above mentioned study, with the Chairman to determine the amount of legal aid, with the possibility of participation by the other organizations (Georgia Hospital Association and Georgia Hospital Governing Board) so that an exact amount can be determined, if such extra legal consultation is necessary.

(2) *Report of Public Service Board Activity:* Dr. Bishop stated that there is a plan to appoint a Subcommittee on Medicine and Religion with Dr. Harrison Reeves as Chairman; and that the physical fitness program will be implemented further.

(3) *Georgia Society of Association Executives:* Mr. Moffett's request for Council approval of his membership in the Georgia Society of Association Executives was discussed. On motion (Jones-Wolff) it was voted to approve this request and pay the dues of \$18.75. These funds to be taken from the Contingent Fund.

(4) *Student American Medical Association Letter:* A letter

from Mr. L. E. Brown, of the MCG, giving a Delegate's Report of the 13th SAMA Convention, was read. On motion (Goodwin-Jones) it was voted to write Mr. Brown and thank him for his support and assure him of the continued cooperation of MAG.

Chairman Simpson called for a recess of Council meeting at 4:20 p.m.

* * * * *

The June 9th meeting of MAG Council was reconvened at 8:10 a.m. by Chairman Simpson.

National Legislative Committee Report

Dr. Walker reported on certain legislation of interest to the MAG, particularly H.R. 3386, the "Maternal and Child Health and Mental Retardation Planning Amendments of 1963," and H.R. 3689, the "Mental Retardation Facilities Construction Act of 1963." He read certain changes which the AMA had recommended. After discussion, on motion duly made and seconded, it was voted to support these bills as the AMA had done, with the changes as stipulated.

The Washington visit on May 23, 1963, was reviewed by Dr. Walker and Mr. Moffett and they stated the results of the conversations with the Georgia Congressmen.

Dr. Walker stated that the Legislative Board budget was overdrawn and in Dr. Braly's absence requested an appropriation of an additional \$200.00. On motion it was voted to approve the request for \$200.00 for the Legislative Board, the money to be taken from the Contingent Fund.

The hearings on the new King-Anderson Bill, H.R. 3920, tentatively set for July 20th were discussed, and the program of letter writing was presented to Council. It was requested that members of Council write their own Congressmen and report to MAG Headquarters so that the progress of the campaign can be followed.

In connection with the above letter writing campaign, the Headquarters Office will write each Councilor at the proper time before the hearings. It was suggested that a copy of each letter written be sent to Wilbur Mills.

Dr. Mauldin then made a motion that Council give Executive Committee authority to approve any testimony that might be given to the Ways and Means Committee. This motion was approved.

At the conclusion of the Legislative report, on motion (Walker-Mauldin) it was voted to approve this report as a whole.

1963 MAG House of Delegates Actions

Speaker of the House Walker asked Council's approval on the suggested list of House of Delegates actions, which he read. At the conclusion, on motion duly made and seconded it was voted to approve the report of the Speaker of the House as a whole.

Expansion of Kerr-Mills Program in Georgia

Dr. Mauldin reported on a breakfast meeting with Governor Sanders, at which time the possible expansion of Kerr-Mills in Georgia to a MAA program had been discussed. The Governor had expressed interest in this expansion. Of recent date certain funds had been made available to the Governor, and Dr. Mauldin stated that a visit to the Governor would be necessary in order to get a definite commitment from him regarding the expansion of the program, and Dr. Mauldin was instructed to make the MAG position known to the Governor as soon as possible.

State Board of Health Appointments

Dr. Goodwin discussed the appointments to be made by the First, Second and Ninth Districts. The Second and Ninth Districts have sent in nominations, but the First District has not replied. On motion duly made and seconded it was voted to write the First District to name two people and to notify MAG Headquarters immediately.

New Business

(1) *Interprofessional Council Resolution* was read by Dr. Simpson. This resolution is on physician ownership of Drug Stores. On motion (Alexander-Wolff) it was voted that Council go on record as opposing any change in the present standards and to instruct the AMA delegates in this regard.

(2) *Georgia Pharmaceutical Association Resolution:* This Resolution states the Georgia Pharmaceutical Association's opposition to the socialization of medicine through the Social Security System or other governmentally sponsored schemes. On motion it was voted to approve this Resolution and to thank

the Georgia Pharmaceutical Association for their action in this regard.

(3) *AMA Delegates Report*: Dr. Chambers discussed business to be brought before the AMA House of Delegates;

(a) AMA Resolution No. 6 regarding composition of AMA Council on Medical Education and Hospitals.

(b) Podiatry: To be discussed with the Stover Commission, which commission is studying this matter. On motion it was voted to instruct the AMA delegates to support any resolution which would limit the podiatrists.

(c) "Operation Hometown Resolution": Dr. Chambers read a proposed Resolution to be submitted to the AMA House of Delegates on "Operation Hometown." On motion (Walker-Alexander) it was voted to approve the introduction of this resolution.

(4) *A proposal to change the Constitution and Bylaws* so that a Vice Councilor can vote in the absence of the Councilor in an instance similar to the Muscogee County Medical Society, where the Councilor resigned after the Annual Session, the Vice Councilor became the Councilor, and a new Vice Councilor was elected by the society, was made by Dr. McDaniel. The formality in question is that the Vice Councilor was not installed at the MAG General Assembly, and is, therefore, a "nominee" according to the Constitution and Bylaws and cannot vote. On motion (Dillinger-McDaniel) it was voted to refer this to the MAG Attorney to draw up a Bylaw, and refer it to the Constitution and Bylaws Board, for report back to Council. This change would allow a Vice Councilor, who was elected at some time after the Annual Session, to vote in the absence of the Councilor until such time as he could be formally installed at the time of the next Annual Session.

(5) *Legal Retainer Fee*: Dr. McDaniel reported that the MAG Attorneys had asked for an increase in the retainer fee. Mr. Shackelford discussed the reasons for this request. This matter had been discussed at the Executive Committee meeting prior to this Council meeting, and a committee had been appointed to discuss this matter with the attorneys. Council will be informed of the results of these deliberations.

(6) *Private Financing of Hospitals*: Dr. Hatcher asked Dr. Mauldin to present this to Council for possible reference to the AMA House of Delegates. After discussion it was received for information only.

(7) *Date and Site of September Council Meeting*: On motion it was voted to meet September 28-29, 1963, at the Cloister Hotel, Sea Island.

Chairman Simpson then called for a rising vote of thanks

for Dr. and Mrs. Chambers and Dr. and Mrs. Cowart for their hospitality as hosts at this Council meeting

There being no further business the meeting was adjourned at 10:25 a.m.

* * * * *

The MAG Retirement Plan

Prerequisite for Membership in Plan:

Have been a full-time salaried Employee for two (2) full years.

Amount of Contribution:

Discretion of Council—must be voted each year. Government will reimburse for portion of Medicare employees.

Allocation of Contribution to Employees' Accounts:

According to number of points of Member compared to total points of all Members. Two (2) points for each year of service and one (1) point for each \$100 of annual salary.

Trustee:

Fulton National Bank; their charges will be between \$130 and \$140 a year in early years.

Retirement:

Normally at age 65; can be later if Council agrees or up to five (5) years earlier if Council agrees and Employee wishes.

Benefits at Retirement:

Amount in Employee's account can be paid as directed by Administrative Committee. Some ways: (2) lump sum; (b) purchase of annuity; (c) establishment of separate trust.

Benefits at Death Prior to Retirement:

Amount in account paid to Employee's designated beneficiary or beneficiaries.

Benefits Upon Termination:

If Employee fired for fraud or dishonesty, no benefits. If for any other reason, Employee will receive a percentage based on number of years of service: 0-5 years, 0%; 5 years, 10%; 6 years, 20%; 7 years, 30%; 8 years, 40%; 9 years, 50%; 10 years, 65%; 11 years, 80%; 12 or more years, 100%. Any amount left goes to balance of other Member's account.

Other Approval:

After adoption by Council, Plan and Trust must be submitted to Medicare and OAA offices and to the Fulton National Bank for suggestions. After approval and execution, application will be made to the Internal Revenue Service for ruling that Plan and Trust qualify as exempt under tax statutes.

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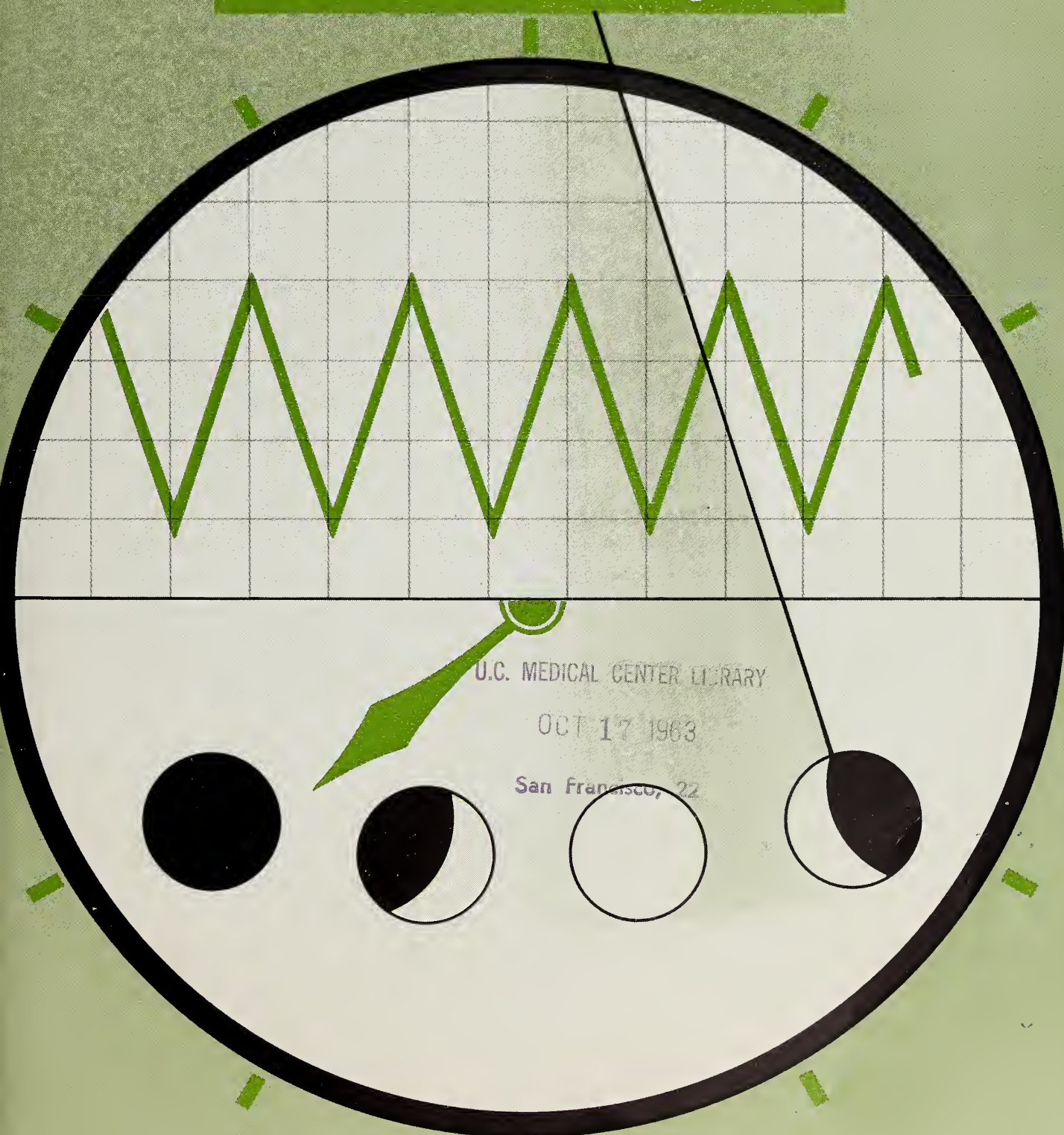
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THE BIOLOGICAL CLOCK / See page 403



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Contents

Scientific Articles

SELECTION OF PATIENT AND DRUG FOR CANCER CHEMOTHERAPY

Elton Watkins, Jr., M.D., and Robert D. Sullivan, M.D. . . . 389

RUPTURE OF THE PREGNANT UTERUS, A REVIEW OF NINETEEN CASES

Donald E. O'Rourke, M.D., and Evans J. Nichols, M.D. . . . 393

EVALUATION OF OPIATES FOR PAIN AND PREMEDICATION

John E. Steinhaus, M.D., and William J. Lee, B.S. . . . 396

ACUTE HEMATOGENOUS OSTEOMYELITIS

H. Benton Bridges, M.D.; Floyd E. Bliven, M.D.,
and James W. Harkess, M.D. . . . 399

Editorials

THE BIOLOGICAL CLOCK IN CLINICAL MEDICINE . . . 403

"FROM LITTLE ACORNS" . . . 404

HALOTHANE (FLUOTHANE) . . . 405

Features

How Well Are We Telling

Our Story? . . . 392

President's Letter . . . 407

Cancer Page . . . 409

Heart Page . . . 411

Legal Page . . . 413

Mental Health Page . . . 414

Physician's Bookshelf . . . 415

Abstracts . . . 417

The Association

Deaths . . . 419

Societies . . . 419

Personals . . . 419

Executive Committee of
Council Meeting, July 17 . 420

Advertising Index . . . 50A

Cover

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SELECTION OF PATIENT AND DRUG FOR CANCER CHEMOTHERAPY

Elton Watkins, Jr., M.D., and Robert D. Sullivan, M.D., *Boston, Massachusetts*

■ ***Striking clinical benefit has been
obtained with regional chemotherapy.***

AS A RESULT of the rapid progress in cancer research, increasing numbers of chemotherapeutic compounds are being presented for clinical use. New techniques for administration of these chemicals have shown promise in the control of advanced cancer localized to one region and unsuitable for conventional surgical or roentgen treatment. A mass of literature is being presented claiming efficiency of chemotherapeutic agents in many different forms of cancer.

No Specific Indication

These reports do not cite specific indications for the use of the chemotherapeutic agent. The fact is documented merely that the drug has produced a given response in a certain form of cancer. It is not apparent that the numerous new forms of alkylating agents act in a dissimilar manner although the speed of action varies. There is no convincing evidence that a difference in therapeutic activity or toxicity exists among the various alkylating agents in spite of the variation in the speed of action. Preliminary reports of various cancerocidal antibiotics, such as actinomycin D or streptonigrin (toxic compounds), give little information concerning the particular clinical situation in which these agents might be of value since the agents are still under development. The types of patients who might derive benefit from regional administration of cancer chemotherapy have not been clearly delineated. At the present time we prefer regional arterial infusion to any of the localized perfusions with a heart-lung machine. In the regional infusion technique, a fine plastic catheter is placed within the artery supplying a disseminated carcinoma and antimetabolite solution infused for periods of days to weeks. This permits the use of agents which

have slow action, such as the fluorinated pyrimidines. The regions suitable for regional infusion therapy are shown in Table I.

All patients in whom the presence of recurrent or disseminated cancer has been established are not candidates for chemotherapy. Only a small percentage of patients with disseminated recurrent carcinoma may obtain benefit from systemic chemotherapy and, as a consequence, careful selection of the patient is mandatory to prevent serious harm from the indiscriminate use of the drugs. Factors to be evaluated include the type of cancer, the stage of the disease, and the particular clinical problem presented by the patient. The experience of the physician in the use of the compound to be administered is also a prominent factor in considering its use.

Restricted Use

Since the available drugs produce only occasional benefit for a relatively short period of time, usually associated with moderate toxic side effects, their use should be restricted to situations in which definite palliation is needed: (a) the type of cancer should be known to be sensitive to the desired agent; (b) the patient should be in a preterminal state; and (c) the progression of the disease should be apparent, associated with symptoms and disability that cannot be controlled by symptomatic therapy. At present there is little justification for the casual use of chemotherapy in an asymptomatic patient on the basis that such therapy may delay the onset of symptoms or retard the growth of the tumor, thus prolonging life. It is our firm belief that the disease should be of sufficient severity to warrant the use of the compound.

Several types of compounds are available that have practical therapeutic value: (a) the alkylating agents, (b) the antimetabolites, and (c) the antibiotics. Table II illustrates the various compounds which are currently in use and the types of neoplasm in which favorable responses have been reported. The alkylating agent, nitrogen mustard, is useful for hospitalized patients. Thio-Tepa, or Cytosan, can be conveniently administered to ambulatory patients. The antimetabolite compounds, such as methotrexate or the fluorinated pyrimidines, are of value in the treatment of certain types of acute leukemia, choriocarcinoma in the female, and various malignancies of the gastrointestinal tract, breast, ovary or bladder. Cancerocidal antibiotics have reached the level of clinical trial. Actinomycin D is the only compound in this category. It has proved to be of clinical benefit, showing activity against several different types of solid tumors in infants and children. Regulation of drug dosage is difficult and extreme toxicity may develop. It should be used with great caution. Recent experience on our service indicates that the antibiotic, Streptonigrin, can be given effectively for management of advanced carcinoma of the lung and the hitherto prohibitive toxic

symptoms reduced by precise continuous intravenous administration. Details of this form of management will be discussed in successive publications.

Many forms of advanced cancer remain localized throughout their evolution and produce disability and death as a result of uncontrolled, but localized, growth. Cancer of the head and neck, cancer of the cervix and bladder, primary brain cancer, and metastatic cancer of the liver are in this category. These forms of cancer may be susceptible to control by regional chemotherapy. Careful selection of the patient is of extreme importance. The proper selection of patient and form of therapy correlate with any beneficial results that may be obtained from these methods of therapy.

Our current preference is the technique of prolonged continuous arterial infusion. This method of therapy involves the continuous 24 hour infusion of a chemotherapeutic agent through a fine polyethylene catheter inserted into a known site in the arterial blood supply of the tumor. The cancerocidal compound is infused for periods of one to four weeks or more alone in doses which the entire body can tolerate, or in massive doses with systemic administration of the specific antidote to neutralize toxic symptoms. Details of this form of treatment have been published.¹⁻⁵

TABLE I
NEOPLASMS SUITABLE FOR INFUSION CHEMOTHERAPY

Neoplasm	Regional Artery Catheterized	Preferred Method of Catheter Introduction
BRAIN AND MENINGES	Internal carotid artery	Open direct introduction
FACE	Common carotid artery	Retrograde passage from temporal artery
ORONASAL AND PHARYNGEAL CAVITIES	Common carotid artery	Retrograde passage from temporal artery
With low-lying or posterior cervical extension	Right: Innominate artery Left: Common carotid artery plus Subclavian artery, first part	Retrograde passage from temporal artery Retrograde passage from internal mammary artery or axillary artery
ANTERIOR CHEST WALL AND AXILLA	Subclavian artery, first part	Retrograde passage from inferior thyroid artery
DISTAL ARM With therapy of proximal metastasis Without therapy of proximal metastasis	Subclavian artery, first part Axillary or brachial artery	Retrograde passage from inferior thyroid artery Percutaneous introduction
LIVER, metastatic disease or hepatoma	Hepatic artery	Retrograde passage from gastroduodenal artery
PELVIS Cervix, bladder, colon, urethra, ovary, uterus	Internal iliac arteries (bilateral)	Swaged needle catheter
HINDQUARTER with proximal metastases	Common iliac artery	Swaged needle catheter
LEG without treatment of proximal disease	External iliac artery	Percutaneous introduction
ANTERIOR ABDOMINAL WALL	External iliac artery	Percutaneous or extraperitoneal open introduction

TABLE II
CHEMOTHERAPEUTIC AGENTS AND TYPES OF CANCER SHOWING
FAVORABLE RESPONSE

Drug	Tumor Type
Alkylating agents Nitrogen mustard (HN ₂) Triethylene thiophosphoramide (TSPA) Cytosan	Cancer of lung, breast, ovary and testis; lymphomas and chronic leukemias
Antimetabolites Methotrexate 6-Mercaptopurine	Acute and chronic leukemias
Methotrexate	Choriocarcinoma
5-Fluorouracil	Cancer of the gastrointestinal tract, ovary, bladder, breast
Antibiotics Actinomycin D Streptonigrin	Wilms' tumor; miscellaneous sarcomas Cancer of the lung
Miscellaneous compounds Delalutin o,p,'DDD Vinblastine	Cancer of corpus uteri Cancer of adrenal cortex Lymphoma

Patients to be treated by this form of therapy present a localized, uncontrolled form of cancer which is not suitable for conventional X-ray or surgical treatment. Patients with such disease in the head and neck, without distant metastases, may be suitable for therapy when the disease is confined to the distribution of the carotid or innominate artery. Patients with readily resectable disease should not be included in this group. In some instances patients with an inoperable primary growth and regional node involvement may be candidates for a combination of surgical excision of the node disease and arterial infusion chemotherapy for management or with irradiation of the nonresectable primary lesion.

The Liver Patient

Patients with metastatic disease in the liver may derive considerable palliation by the infusion of an antimetabolite directly into a catheter which has been placed in the hepatic artery at laparotomy. About 25 per cent of patients with cancer of the intestine die as a result of subsequent progressive liver metastases. In these cases, the primary tumor has often been adequately controlled by surgical resection and the liver is the only organ showing progressive involvement. At the Lahey Clinic it is our practice to start infusion therapy through the hepatic artery when the diagnosis of metastatic liver carcinoma has been made at the time of laparotomy. It is possible to do associated operations at the time of placement of this catheter, for example, resection of the primary lesion at the time an hepatic artery catheter is placed for infusion of antimetabolite. We have now seen over nine patients who have obtained sustained benefit from such therapy as evi-

denced by improvement in performance status and liver function tests, and a striking reduction in the large size of the liver. Frequently the complaints that such patients have prior to therapy are the feeling of abdominal distress owing to the bulky size of the liver, anorexia, and weight loss, and these symptoms have been relieved by the regression of liver size and improvement of liver function with infusion therapy.

Patients who have advanced carcinoma of the cervix and bladder can be treated by regional infusion through each hypogastric artery. Similar palliative benefit can be obtained with primary brain tumors or tumors of the chest and abdominal wall or extremities.

Summary

Despite the large number of new cancer chemotherapeutic agents being introduced, there is little information concerning the actual significance of these compounds in clinical practice.

Our experience indicates that the most effective use of the newer compounds is obtained in cooperative groups where the agent is used in a well thought out plan of clinical investigation and where access can be had to a continuing volume of patients. The casual use of these potent compounds on an occasional patient is discouraged. The newer compounds in the antimetabolite-antibiotic class show promise of palliative action. No chemical agents have been developed that are capable of inducing a general cure in disseminated carcinoma. Nevertheless, over the past few years definite advances have been made in the introduction of new compounds and special techniques and procedures for their administration. The clinical situations in which systemic admin-

istration of various chemotherapeutic agents may be of practical value are described.

Our current preference in regional chemotherapy is the use of arterial infusion chemotherapy in which a cancerocidal drug, usually of the antimetabolite type, is introduced into the major arteries supplying a region bearing a carcinoma that is unsuitable for conventional forms of therapy. Striking clinical benefit has been obtained in a significant percentage of patients by this method of therapy.

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How well are we telling our story?

How well are we telling our story? This is asked like a question, but if you take a look at the stars on the accompanying map it's more like an accusation. The truth of the matter is, we are not telling it too well.

As I'm sure everybody knows, stars on the map indicate those places where physicians have given talks to lay groups on just about any subject—medical or non-medical. This month's map represents last month's activity.

The hearings on the King-Anderson bill are just around the corner. We are nearing the time when this bill may be called up before the House of Representatives for a vote. With this possibility in view, everyone agrees that we need to increase any activity designed to expose the fraud which this bill represents. More specifically, we all would agree that now is the time to improve the image of the profession with the people, as they hold the ultimate power to insist or not insist that this legislation be adopted.

Public speaking before civic and other lay groups is the best idea anybody can come up with yet.



RUPTURE OF THE PREGNANT UTERUS

A REVIEW OF NINETEEN CASES

Donald E. O'Rourke, M.D., and Evans J. Nichols, M.D., *Augusta*

- *The most common cause was rupture at the site of a previous classical Cesarean section.*

RUPTURE of the pregnant uterus is one of the most serious emergencies encountered in obstetrics. Eastman² states that rupture of the uterus is responsible for at least five per cent of all maternal deaths.

The purpose of this paper is to review 19 cases of ruptured uterus during pregnancy treated over the past eight years by the staff and private services of three hospitals: The University Hospital, Augusta, Georgia; Eugene Talmadge Memorial Hospital, Augusta, Georgia; and The Macon Hospital, Macon, Georgia. This report covers the period 1955 through 1962. Rupture of the pregnant uterus occurred 19 times in 54,842 deliveries, an incidence of 1:2886. Various authors^{1, 3, 4, 5, 8} report the incidence as being from 1:1204 to 1:1771.

Classification

Most current authors use the following or similar classification:

1. Spontaneous; 2. Traumatic; 3. Rupture following cesarean section. Table I shows the distribution of cases according to this classification.

Rupture at the site of a previous classical cesarean section scar was the most common occurrence. It is interesting to note that there were no cases of rupture involving previous low cervical cesarean section scars. The use of oxytocin was implicated in four instances and may have been a factor in another rupture. Breech extraction resulted in rupture in two patients. Internal version and extraction was the cause of one rupture. Several factors were present in one case with the use of oxytocin followed by fundal

pressure at delivery in the presence of a cephalic presentation and prolapsed arm. Abruptio placenta was also present in this instance, or occurred as a result of these factors. Apparently the diagnosis of placenta previa was not made prior to the external version attempted in the case of transverse lie. Needless to say, either placenta previa or transverse lie is a definite indication for cesarean section.

Site of Rupture

Uterine ruptures are divided into two classes: 1. Complete, with rupture through the peritoneum; and 2. Incomplete, with the uterine muscle torn but with the peritoneum intact. The majority of ruptures in this group were complete, with the occurrence of only three incomplete ruptures. Greenhill states that the anterior wall is most often involved, then the sides, the left most commonly, and least frequently the posterior wall. The location of rupture in these patients is shown in Table II.

TABLE I
CAUSE OF UTERINE RUPTURE

Previous Cesarean Section	
Classical Section, prior to Labor	2
Classical Section, in Labor	5
Spontaneous	
Oxytocin	4
Abruptio	1
Face, Precipitous Labor	1
Undetermined	1
Traumatic	
Breech Extraction	2
External Version, Transverse lie, Placenta Previa	1
Fundal Pressure at Delivery, Abruptio, Oxytocin, Prolapsed arm with Cephalic Presentation	1
Internal Version and Extraction	1
	19

Presented at the 109th Annual Session of the Medical Association of Georgia, May 7, 1963, Jekyll Island, Georgia.

O'ROURKE / Continued

TABLE II
SITE OF RUPTURE

Anterior, in section scar, complete	7
Left Lateral Wall	
Incomplete	3
Complete	4
Right Lateral Wall, Complete	5
	—
	19

There were two maternal deaths in this group of patients. Both deaths were attributed to massive and uncontrollable hemorrhage, and both patients died on the operating room table.

There were eight fetal deaths in this group of patients. Fetal mortality is given by various authors^{1, 3, 4, 7, 8} as being from 29 per cent to 50 per cent and maternal mortality as being from five per cent to 15 per cent. The fetal and maternal mortality in this group is shown in Table III.

TABLE III
MORTALITY

Fetal, 8 Deaths	42.1%
Maternal, 2 Deaths	10.5%

The predominant signs and symptoms in this group of patients are shown in Table IV. Prior to the onset of labor, the most common symptom was severe lower abdominal pain which was sudden in onset. One ruptured uterus was discovered at elective repeat section and this was an incomplete rupture. During labor, the most common sign was shock. It should be emphasized that during labor, the onset of pain, vaginal bleeding or shock should alert the physician to the possibility of uterine rupture. After delivery, profuse vaginal bleeding was the most prominent sign. It is imperative that the uterus be thoroughly examined for rupture anytime there is excessive vaginal bleeding post partum.

TABLE IV
SIGN AND SYMPTOMS

Prior to onset of Labor	
Pain, Bleeding, Shock	1
Pain, Bleeding	1
Pain, Shock	1
Pain	1
None	1
During Labor	
Shock, Bleeding, Pain	1
Shock, Bleeding	1
Shock, Pain	1
Shock	1
None	2
Post-partum bleeding	4
Bleeding, shock	3
Shock	1
	—
	19

Whenever the diagnosis of ruptured uterus is suspected, it is imperative that preparation be made for immediate laparotomy and that ample quantities of whole blood be available. This implies that Type O Rh negative blood be available in every delivery

room on a few minutes notice. A venous cutdown, and preferably two, if time permits, should precede the laparotomy because several transfusions will probably be required.

As soon as blood is available, one should proceed with laparotomy regardless of shock. At laparotomy, the most direct and expedient method of controlling the maternal hemorrhage should be employed. In most cases, a rapid subtotal hysterectomy is the procedure of choice. Occasionally it is possible to denude the edges of the uterine wound and repair the defect. Lacerations through a previous cesarean scar can, as a general rule, be repaired. In instances of laceration into the broad ligament with hematoma formation when accurate identification of the uterine vessels is impossible, one should consider ligating the hypogastric branch of the common iliac artery on the involved side.

The management of these cases is given in Table V. In nine instances, a supracervical hysterectomy

TABLE V
MANAGEMENT

Supra Cervical Hysterectomy	9
Repair of Uterus and Tubal Ligation	2
Repair of Uterus	2
Total Hysterectomy	6
	—
	19

was done. In two cases, the uterine rupture was repaired and tubal ligation was done. There were two patients in whom a repair of the rupture was done without tubal ligation apparently with anticipation of a future pregnancy. It should be noted that in this group of patients, only ruptures occurring in previous cesarean section scars were repaired.

Summary and Conclusions

During the eight year period, 1955 through 1962, rupture of the pregnant uterus occurred 19 times, an incidence of 1:2886. The maternal mortality was 10.5 per cent and the fetal mortality was 42.1 per cent.

Rupture of a cesarean section scar was one of the most common types of rupture, and it is difficult to take issue with the dictum "once a cesarean, always a cesarean."

Obstetrical trauma was the cause of five ruptures. Internal version and extraction is an extremely hazardous procedure and should be attempted only by an experienced individual. Cesarean section is considered to be preferable to internal version and extraction.

The dangers of oxytocin to stimulate labor must continue to receive attention.

The occurrence of excessive vaginal bleeding or sudden shock during labor or following delivery should alert the physician to the possibility of rup-

tured uterus. Once the diagnosis is made, immediate laparotomy is indicated.

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MEDICAL PROGRESS ASSEMBLY ADDS TWO NEW FEATURES TO PROGRAM

A speaking faculty of 30 distinguished physicians will present latest developments in a broad range of medical subjects at the Sixth Annual Medical Progress Assembly in Birmingham, October 6-8.

800 Expected

Georgia physicians are invited by General Chairman John M. McMahon, M.D., to join with an expected 800 who will attend one of the South's fastest-growing postgraduate medical educational meetings.

Lecture subjects will include arthritis, cardiology, diabetes, endocrinology, gastroenterology, medicine, neurology, obstetrics-gynecology, pathology, pediatrics, radiology and surgery. The Assembly has been accepted for 15 hours of Category I credit by the American Academy of General Practice.

New features this year will be pre-Assembly programs on arthritis and diabetes to which everyone is invited. Also there will be seminars on specialized subjects in addition to the Assembly's general sessions.

Program of Renown

Indicative of the renown of this year's program speakers are: Dr. Richard J. Bing, Professor of Medicine, Wayne State University, Detroit — Coronary Reserve, What It Is and How to Measure It; Dr. Isadore Snapper, Director of Medicine and Medical Education, Beth-El Hospital, New York — What is New in Hyperparathyroidism; Dr. Edward T. Peter, Department of Surgery, Medical School, University of Minnesota — The Use of Gastric Freezing in the Treatment of Duodenal Ulcer; Dr. John A. Spittell, Jr., Mayo Founda-

tion — The Use of Vascular Clues in Diagnoses; Dr. Champ Lyons, Medical College of Alabama, Dr. Frank Glenn, Cornell — Infection as Related to Newer Antibiotics; Dr. F. A. Simeone, Western Reserve University School of Medicine — The Autonomic Nervous System; Dr. Snapper — Clinical Pathological Conference; Dr. Judson Van Wyk, University of North Carolina School of Medicine, Dr. Robert F. Shaw, Massachusetts General Hospital, Dr. Harry C. Shirley, The Children's Hospital, Birmingham, and Dr. James A. Pittman, University of Alabama Medical Center — Thyroid Diseases in Children; Dr. William Blakemore, Chairman, Department of Surgery of the Graduate School of Medicine, University of Pennsylvania — Surgical Treatment for Hypertension.

Entertainment

Special entertainment events have been planned for both physicians and their wives. The program will open with a reception and buffet at the Tutwiler Sunday evening. Other social activities will include a dinner and dance at Vestavia Country Club Monday evening and a luncheon and fashion show for the doctor's wives. Door prizes will be awarded and refreshments will be served during breaks for viewing the technical exhibits.

Sponsorship

The Assembly is sponsored by the Birmingham Academy of Medicine, comprised of 160 younger specialists, with the cooperation of the Jefferson County Medical Society and the Alabama Academy of General Practice.

CHROMOSOMAL ANALYSIS AVAILABLE

Dr. John T. Godwin, Atlanta, announces the availability of chromatin sex determinations and chromosomal analysis. Through a joint effort of the Bioengineering Section, Georgia Tech, and the Cytology Laboratory, Department of Pathology, St. Joseph's Infirmary, a Research Cytotechnologist is now engaged

in the study of Cytogenetics.

Physicians having patients upon whom such studies appear indicated such as those with sexual maldevelopment (infertility, primary amenorrhea, abnormalities of genitalia), may obtain information concerning this project by calling Dr. Godwin at JA. 5-4681, Atlanta.

EVALUATION OF OPIATES FOR PAIN AND PREMEDICATION

John E. Steinhaus, M.D., and William J. Lee, B.S., *Atlanta*

■ *A comparison of both analgesic and adverse actions is necessary for the evaluation of opiate analgesics.*

THE PROBLEM of selecting the most effective drug for a given therapy is very difficult due to the inexactness of the methods which we use to measure drug actions. In the case of opiates it is particularly a problem because the evaluation of therapeutic action requires the measurement of a subjective effect, namely analgesia. If one can determine the analgesic potency of an opiate, it is still necessary to evaluate the adverse or side effects produced by these doses, since a comparison of the dosages required to produce analgesia on the one hand and toxicity on the other determines the therapeutic ratio and the usefulness of a drug. Since opiates can produce all degrees of depression of the central nervous system, including anesthesia with high dosage, it is particularly important to learn the adverse reactions produced by equi-analgesic dosages of these drugs in order to select the drug which produces the greatest benefit with least hazard to the patient.

Evaluation of Analgesic Action

The study of experimental pain, by many ingenious methods, has proved to be a very limited means for the evaluation of analgesic agents, such as the opiates. Beecher and co-workers¹ made important advances with the introduction of the concept of pathological pain into the study of analgesic agents. It was their belief that "the reaction" to painful stimuli played a large part in the sensation of pain and consequently pain could only be studied

in the clinical situation. In addition, they demonstrated the importance of the double blind technique and adequate statistical analysis. The problem of the placebo reactor was also revealed by their studies. In their studies they used the verbal response of the patient as an indication of pain and its relief. They asked the patient to indicate the degree of his pain in five degrees, from none to very severe. These studies have usually required a comparison of two agents in selected doses in a relatively large number of patients.

In our studies we have been impressed with the clinical practice of evaluating pain and discomfort by the appearance and behavior of the patient. As a consequence, we devised a rating system for evaluating a number of aspects of behavior on a seven point scale from no discomfort to very severe discomfort. Typical rating scales are shown in Table I for Bodily Movement, Breathing Regularity and Facial Expression.

TABLE I

TYPICAL RATING SCALES

Bodily Movement	Breathing Irregularity	Facial Expression
1. None	7. None	1. Extremely tense and uncomfortable
2. Very little	6. Very little	2. Very tense and uncomfortable
3. Little	5. Little	3. Moderately tense and uncomfortable
4. Moderate	4. Moderate	4. Slightly tense or relaxed
5. Much	3. Much	5. Moderately relaxed comfortable
6. Very much	2. Very much	6. Very relaxed comfortable
7. Extreme	1. Extreme	7. Extremely relaxed comfortable

Presented at the 109th Annual Session of the Medical Association of Georgia, May 5, 1963, Jekyll Island, Georgia.

This investigation was supported by a grant from the Knoll Pharmaceutical Company.

With proper statistical evaluation a comparison of the action of different opiate analgesics can be determined. In our study we assumed, consistent with common clinical opinion and the standard textbooks of pharmacology, that equi-analgesic dosage for morphine and meperidine (Demerol) was ten mg. and 100 mg. respectively. The results of our comparative study⁴, strongly indicated that this ratio is in error in that ten mg. of morphine is not as analgesic as 100 mg. of meperidine (Demerol) or two mg. of dihydromorphinone (Dilaudid). Additional studies have suggested that the ratio between these drugs is more nearly meperidine 75 mg., morphine ten mg. and dihydromorphinone 1.5 mg.

Opiates for Premedication

The purpose of drugs given preoperatively is to reduce apprehension in the patient. Within the past few years a considerable discussion has arisen over the usefulness of opiates for this purpose. Using a technique similar to that described for analgesic effect, we compared meperidine with pentobarbital, promethazine and hydroxyzine in a double blind study². Our results suggest that meperidine is not as effective as the other premedicating drugs. Unless pain is a major consideration it would appear that meperidine is a questionable choice for premedication.

Adverse Or Toxic Effects

As we previously indicated, the most advantageous choice of an opiate could not be made without considering the side effects. The opiates are noted as marked respiratory depressants; however, their effect on circulation is less well appreciated. A comparison of the respiratory, and circulatory effects of meperidine, morphine, and dihydromorphinone was carried out in healthy volunteers. Respiratory depression was determined by measuring the respiratory response to carbon dioxide as previously reported by numerous workers⁴. Circulatory depression was determined by the use of the tilt test in which a subject is rapidly placed in a 60° tilt from the supine position. This maneuver puts a stress on the circulation and requires effective compensatory actions to maintain adequate circulation to the head.

In our study we used healthy volunteers in a cross-over experimental design. By this method each subject received each of four test drugs at suitable intervals. The drugs were administered by a random double blind technique and the dosage was determined on a weight basis. Three levels of dosage were selected and the dose for a 150 pound man is shown in Table II.

During a control period the subject was administered 95 per cent oxygen and five per cent carbon dioxide and the respiratory response was determined

TABLE II
OPIATE DOSAGES FOR 150 POUND PATIENT IN MGM

	Low	Medium	High
Dihydromorphinone	1.0	1.5	2.0
Morphine	7.5	10.0	12.7
Meperidine	50.0	75.0	100.0

by measuring the increase in ventilation produced by the increased carbon dioxide. This test was repeated at suitable intervals following the drug administration. The effects of these drugs on respiration are illustrated by the results of the low dosage series as shown in Figure 1. The depression of the respiratory response to carbon dioxide is very similar for the three drugs in the test doses, (low range) in contrast to the normal response with the administration of the placebo. If the doses selected were equi-analgesic there would appear to be little basis for selecting one agent over the others because of respiratory depression. The earlier reports that meperidine did not depress respiration are not substantiated and indicate that rigorous testing should be performed before we accept such statements about new members of the opiate series.

Cardiovascular Effects

Although opiates are reported to have little effect on the myocardium, recent reports suggest rather marked action on the physiological factors which control blood pressure. The tilt test determines the effectiveness of the compensatory mechanisms which maintain blood pressure in the upright position and consequently it is valuable in assessing the adequacy of these homeostatic mechanisms.

Alteration in cardiovascular function produced by the action of opiates was assessed by changes in pulse, blood pressure and the symptoms commonly

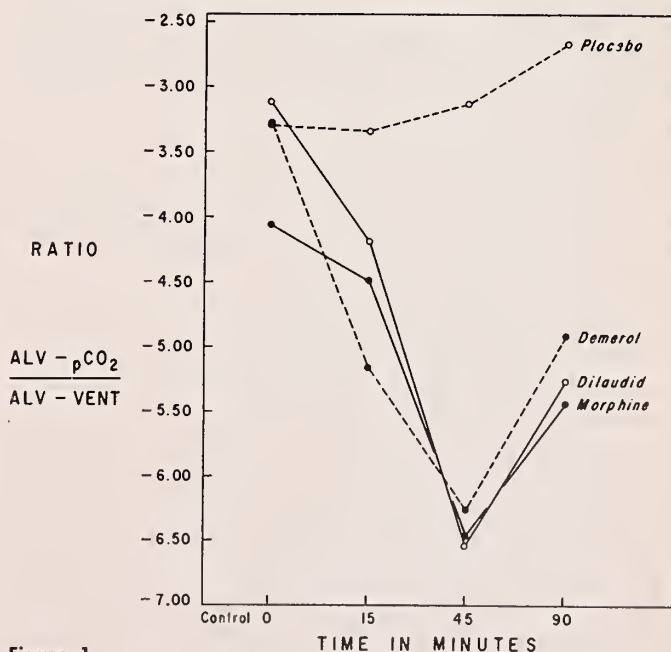


Figure 1.

The depression of respiration as shown by a decrease response to carbon dioxide by the low dose range of the opiates.

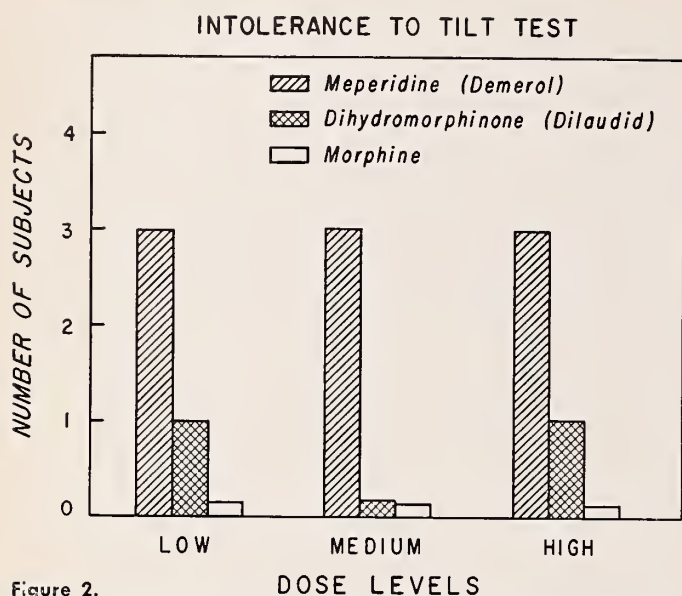


Figure 2.

Intolerance to 60° tilt in four subjects after administration of three opiates in three dose ranges.

associated with hypotension, such as, pallor, perspiration, nausea, and syncope. If the subject stated that he could no longer tolerate the tilted position he was returned to the horizontal position before the 15 minute period had transpired. The intolerance to tilt (as determined by subject) is shown in Figure 2 for all three dosage series.

A high proportion of the subjects did not tolerate the tilt in each dose level with meperidine. Of the 12 trials with meperidine, nine showed intolerance. In contrast there were only two instances with dihydromorphinone and none with morphine. These differences are statistically significant, although the question can always be raised as to whether a sample of eight persons accurately reflects the behavior of the general population. Our own clinical experience with hypotension following meperidine is consistent with these findings. Measurement of blood pressure

changes did not show the marked changes that might be expected with the above clinical symptoms. The lesser proportion of severe blood pressure changes can probably be explained by the compensatory mechanisms exhibited by these healthy young men.

Conclusions

It is strongly suggested by our studies that much investigation is needed to properly evaluate the analgesic effectiveness of various members of the opiate series. It would appear that there is a clinical tendency to use relatively more potent analgesic doses of meperidine than morphine since ten mg. of morphine approximates 75 mg. of meperidine. Once equi-analgesic doses have been ascertained, it is necessary to compare the adverse effects of these dosages. In the above ratio, morphine, meperidine and dilaudid appeared to be equally depressant to respiration. The circulatory studies indicated that meperidine produced a significantly greater incidence of intolerance to tilt (cardiovascular instability) than did either morphine or dihydromorphinone. These findings indicate that the widespread substitution of meperidine for morphine, which has occurred during the past several years, is not justified.

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MEDICARE COVERAGE EXPANDED

According to instructions received by your Medicare Department from the Office for Dependents' Medical Care in Washington, D. C., the following changes are being made in coverage under the Medicare Program in Georgia:

1. On and after July 1, 1963, the accompanying dependents of active duty military personnel, who are members of the land, sea and air forces of North Atlantic Treaty Organization countries stationed or passing through this country, will be entitled to the same care under the Medicare Program as those dependents of members of the uniformed services. The standard Identification Form DD Form 1173 will be furnished to those dependents and all contractual pro-

visions, and criteria as to scope of care and eligibility will be the same as for dependents of members of our uniformed services.

2. Under the new Medicare contract effective as of March 1, 1963, the full fee allowed under the Medicare Schedule of Allowances for newborn care may be charged by all physicians regardless of whether or not they are the delivering physician.

3. Effective with the new Medicare Contract year which began on March 1, 1963, your Medicare Department will be making payments to the physicians of Georgia for services rendered under the Medicare Program one time per month.

ACUTE HEMATOGENOUS OSTEOMYELITIS

H. Benton Bridges, M.D.; Floyd E. Bliven, M.D.; and James W. Harkess, M.D., *Augusta*

■ *Clinical experience with thirty cases
is presented and discussed.*

DURING THE TWENTY YEARS since the introduction of penicillin, many physicians have advocated medical therapy as superior to surgical treatment of acute hematogenous osteomyelitis. We do not believe this is to be true.

Incidence

A total of 30 cases is reported in this series. There are 20 males and ten females. Nineteen are Negro and 11 white. The ages of the children at the onset of illness were from three weeks to 19 years with the predominance of cases being ten or 11 years old.

Pathology

Acute hematogenous osteomyelitis begins as a focus of infection in the metaphysis of the bone. As the process progresses it spreads through three routes. First, it may spread by direct extension into the medullary canal. Second, it may rupture through the cortex of the bone forming a subperiosteal abscess. Third, it may extend through the epiphyseal plate into the joint. The epiphyseal plate is very resistant to infection and joints are infrequently involved except in the hip where the capsule of the joint encloses the metaphysis and a septic joint secondary to the disease is frequent.

The pathology is related to the blood supply of the bone. In children the epiphyseal-metaphyseal area has a very luxuriant blood supply. Trueta has shown that at this age the nutrient vessels terminate at the epiphyseal plate in tortuous capillaries which

loop back on themselves expanding into large sinuses. There is an eddying effect of the blood and deposition of the organisms here.

The periosteal vessels supply the outer one-third of the cortex. As the subperiosteal abscess, which almost always occurs, spreads there may be complete dissection of the periosteum from the bone. This impairs the blood supply and sequestration occurs. Simultaneously an involucrum is formed by the periosteum. If areas of periosteum are destroyed by the infection, no involucrum will occur in this area. The subperiosteal abscess may rupture into the soft tissue.

Clinically there are two varieties of acute hematogenous osteomyelitis. The first is the fulminating systemic disease. The patient presents an overwhelming toxemia. It is characterized by rapid pulse, high sustained fever, chills, shock, and signs of an osteomyelitic lesion. In this severe type, the patient may die before the bone lesion is evident.

More Common

The second type, and more common, is a lesion of bone manifested by pain and tenderness over the area of involvement. There is fever, swelling and limitation of motion of the extremity involved. The most important sign is tenderness over the metaphysis. Commonly erythema and limitation of joint motion is present. Effusion of the knee joint is often found when the upper tibia or lower femoral metaphyses are involved.

In this series there was a history of pain in 28, fever in 25, swelling in 22 and pseudoparalysis in 23 patients. On admission 23 patients had tender-

Presented at the 109th Annual Session of the Medical Association of Georgia, May 5, 1963, Jekyll Island, Georgia.

BRIDGES / Continued

ness of the involved area. Local swelling and heat occurred in 18 patients. There was limitation of motion of the contiguous joint in 13 cases but joint effusion was found in only five cases. In five cases seen one month or more after the onset of symptoms, abscesses were already draining.

Fever was not present in one-third of the cases. The temperatures ranged from normal to 40.4°C. Those afebrile had all received prior antibiotic therapy.

While one would expect a leucocytosis with an acute active infection, this is not prominent. The range was from 5,000 to 40,000 with the majority of patients between 6,000 and 11,000.

Kessel in 1956 concluded that halfhearted antibiotic therapy for acute osteomyelitis often masked the signs and symptoms of the disease and gave a false sense of security in the early stages.

Twenty-one of our patients had some antibiotic therapy prior to admission. This in most instances consisted of one or two injections of penicillin. All but three of the patients with normal white counts had received antibiotics. From this it would appear that inadequate amounts of antibiotics will modify the systemic effects of the infection while allowing continued bone destruction. Thus, the disease may enter the chronic stage which could have been avoided by early, adequate therapy.

Bacteriology

In other series staphylococcus aureus is usually the predominant etiological organism. Green and Shannon in 1932 reported streptococcus pyogenes as more common in children under two years of age. They felt this was due to the fact that infants have more respiratory infections and less immunity to streptococcus.

Of these cases there were 19 positive cultures of coagulase positive staphylococcus aureus and two of coagulase negative staphylococcus albus. There were five patients with sterile cultures. Eleven patients had organisms resistant to penicillin; all of these had received antibiotics prior to admission. Blood cultures were positive in four of ten cases.

Roentgenographic Findings

Roentgenographic changes in bone do not appear until ten to 14 days after onset of the disease and may be further delayed in patients receiving chemotherapy. These changes begin with focal areas of radiolucency in the metaphysis. Then local demineralization and formation of involucrum from periosteal proliferation occurs. As the disease process

continues, a varying degree of sclerosis and sequestration occurs. About two-thirds of these cases revealed bone involvement at the time of admission varying from minimal change to overt sequestrum formation. In all instances except one, symptoms had been present for two weeks or more. This child's X-rays show evidence of destruction within seven days. Six of the seven cases with no evidence of bone involvement were seen within three weeks of onset. The exception had been hospitalized and treated with large doses of antibiotics for one month prior to admission.

Bone Involved

Lesions are usually confined to a single bone. Four patients had more than one bone involved. The lower extremity bones were more frequently involved. All five cases of involvement of the proximal femoral metaphysis had associated sepsis of the hip joint.

Differential Diagnosis

The diagnosis of acute hematogenous osteomyelitis is difficult, especially in the early stages. The conditions with which this disease must be differentiated are: cellulitis, rheumatic fever, septic arthritis, bone tumors, tuberculosis, poliomyelitis, fractures, and in infants, scurvy.

Treatment

The treatment of acute hematogenous osteomyelitis has changed markedly since the advent of antibiotics. This has resulted in a profound decrease in the mortality. The death rate prior to antibiotics has been reported as high as 50 per cent. With effective antibiotics, osteomyelitis is no longer a fatal disease.

Prior to antibiotics, the primary cause of death was septicemia directly related to the surgery required for adequate drainage of the abscess.

Since the advent of penicillin therapy, there has been a marked conflict in the methods of treatment. On the one hand is the treatment of the disease of antibiotic therapy without drainage and on the other, antibiotics plus early surgical intervention.

Therapy Indicated

Trueta and Agerholm in 1946 treated 30 cases by both methods. They felt that penicillin therapy was indicated due to the fact that acute osteomyelitis is a systemic disease. However, penicillin does not sterilize an abscess and drainage is imperative to limit further damage to the bone. Kessel believes that 70 per cent of the cases diagnosed in the first 48 hours after symptoms do well on chemotherapy, but if the diagnosis is delayed, the abscess and bone should be drained.

Our present regimen is to institute immediate chemotherapy on admission. Penicillin 600,000 units

intramuscularly every six hours and, in addition, either streptomycin 0.5 grams every 12 hours or a broad spectrum antibiotic are used until the results of culture are available. If marked toxemia is present, the penicillin dosage is raised to higher levels and given intravenously. Even the early lesion is drained. If there is no response to the antibiotics within 48 hours, the area is incised and the cortex windowed. Four children were treated by chemotherapy and immobilization without surgery; three of these were seen within six days after the onset of symptoms and the other case was a 15 year old boy with involvement of the tenth thoracic vertebra who had been under vigorous antibiotic therapy for pneumococcal pneumonia. None of these patients has had residual effects, but the patient with vertebral involvement had spontaneous interbody fusion.

After Onset

The other 26 cases were seen later after onset. Of these, all but three showed bony involvement on admission. Five had involvement of the hip joint along with the osteomyelitis of the femoral neck. One of these was seen after one week but had a severe septicemia and pneumonitis which precluded drainage for three weeks. The hip was aspirated daily and penicillin instilled. At surgery this boy had complete destruction of the femoral head.

The second case was a 13 year old male who had been treated for four weeks before admission to the hospital. During this period he received antibiotics. On admission he had low grade fever, normal white count, and elevated sedimentation rate. His hip was painful on motion and aspiration revealed purulent material. There was no growth on culture. He also had destruction of the femoral head requiring extra-articular arthrodesis later.

Previous Therapy

Of the other three cases, all had previous antibiotic therapy. One had necrosis of the femoral head at the time of drainage. The others were seen within one week after onset. Both were drained. One has only minimal limitation of abduction and internal rotation. Radiographically there is enlargement of the femoral head and narrowing of the joint space. She has been followed for four years.

The remaining cases were treated with antibiotics and drainage. The result obtained was related to the time between the beginning of symptoms and their treatment. The cases seen earliest obtained the best results. The other case is five months since drainage and has no limitation of motion at this time.

Thirteen cases healed primarily. Five cases have been lost to follow-up. Twelve cases developed chronic osteomyelitis. Five of these had sequestrec-

tomies of which four have had no further trouble. The other is too early to judge the result. There were three fractures which have healed. Three of the five cases with septic hip secondary to proximal femoral osteomyelitis have had extra-articular arthrodeses. The other two have only minimal change in the hip. Three have shortening of the involved extremity and one patient has one-quarter inch overgrowth. Three cases have not been followed a sufficient time to judge their results.

Conclusions

1. Inadequate antibiotics are worse than none because the signs and symptoms of the disease are masked.
2. Early treatment leads to good results.
3. Septic joints should be drained as an emergency.
4. Antibiotics alone may not be enough. If there is no improvement within 48 hours, the lesion should be drained and the cortex of the bone windowed.
5. It is desirable to find the causative organism and its sensitivity, as many of the organisms are now resistant to penicillin.

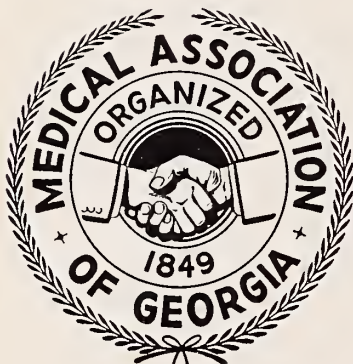
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1964 Annual Session

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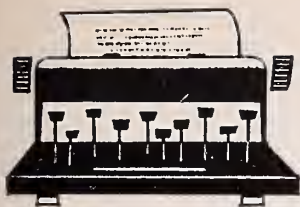
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The Biological Clock In Clinical Medicine

ALTHOUGH even the ancients were aware of periodicity in at least some disease states^{1, 2}, the significance of cyclic recurrences of disease seems little known to modern medicine. Those who are aware of what might be called the "biological clock" almost universally view it as a novelty and of little clinical significance. It is the purpose of this paper to present a number of interesting examples of this phenomenon gathered from the literature and to point out a few possible avenues where this concept might be applied clinically.

A Definition

Before going further it seems best to pause briefly and define what we mean by the term "biological clock." For our purposes, this may be defined as follows: Biological clocks are altered physiological states of body organs or systems which recur or exacerbate periodically with relative independence of external circumstances. The units of time and degrees of accuracy vary from one altered physiological condition to another. As can be readily seen, our definition is very similar to that used by Richter³.

Having defined our purposes and our concepts, let us now turn our attention to a few interesting examples of the biological clock phenomena.

The best known example of the biological clock undoubtedly is the normal female menstrual cycle. However, it is by no means the most accurate. Closely akin to the biological clock of menstruation is the allied condition of cyclic edema which has been thoroughly discussed by Thorn⁴. This entity is a periodic recurrence of edema fluid, occurring predominantly in females in the menstrual years and closely related to the menstrual cycle. It can be associated with considerable weight gain, discomfort and consternation to the patient.

Another very interesting example of the clock phenomena is that of cyclic agranulocytosis. In this regard, Embleton⁵ reported an interesting case in which he described a woman who came to him because of recurrent mouth ulcers appearing at cyclic intervals of approximately 17 to 19 days and accompanied by a granulocytopenia. She had also observed several similar attacks of mouth ulcers several years earlier.

Perhaps the most interesting example of all is an illustration given by Richter³ in his interesting article on the biological clock. In this illustration he brings out the fact that the star of the Cambridge soccer team had a recurrent hydrarthrosis of such amazing predictability that the institution was able to arrange its schedule in such a manner that none of their games fell at a time when their star player would be incapacitated by hydrarthrosis.

Peptic Ulcer

Jahiel¹ did considerable work on the periodicity of peptic ulcer. Among several case histories, he pointed out a 56 year old male with peptic ulcer who experienced three to four bouts of epigastric pain per year and in whom the disorder exhibited no changes in rhythmicity or characteristics for a time period in excess of 15 years.

No discussion of clock-like phenomena would be complete without at least mentioning that notable work in this general area has been done by Reiman.⁶ Of special interest is an article written by this author in 1957 and entitled "Periodic Diseases."

Clinical Application of "Clocks"

Thus far the presence of biological clocks has been cited in the literature predominantly in connection with essentially benign processes. There seems to be no justifiable reason why this concept should be so confined, and we wonder if its presence in other more pathological states has not been sim-

ply overlooked. If the clock mechanism does exist in serious clinical conditions, a careful search for its presence and study of its physiological basis might conceivably be most rewarding in our search for the cause and cure of diseases.

In a presentation at the International Hematology Convention at Mexico City (1962), Frenkel et al⁷ presented an interesting paper entitled "The Biological Clock Effect on Desoxyribonucleic Acid Synthesis." This group performed studies on the incorporation of tritiated thymidine into DNA in multiple body tissues of experimental mice. Some of these animals were tumor bearing while others were not. The authors found that temporal variation played a role in the speed "of incorporation of precursors into DNA." They further stated that, "The differing temporal peaks of incorporation in the marrow and tumor suggest that the proper timing of a cytotoxic agent may be an important factor in its therapeutic effectiveness." Certainly if we could develop isotopic techniques for measuring peak uptake of DNA precursors by normal and cancerous human tissues, we could treat cancer victims with higher doses of cytotoxic agents with minimized danger to the patient and maximum efficacy.

A last example of the clinical application of the biological clock principal evolves around steroid therapy. From information given us by experienced workers in the steroid field, it appears that maximum hydrocortisone production occurs around the hours of 5:00 to 8:00 A.M. in the average individual and the lowest production is from around 8:00 P.M. to 12:00 midnight⁸. Using this information concerning the biological clock of human hydrocortisone pro-

duction, a physician could, in at least some patients, plan to give supplemental hydrocortisone at such a time as to cause minimal adrenal suppression while still obtaining some therapeutic benefit.

Summary

An attempt has been made to define the term "biological clock" and several examples of human biological clocks have been given as illustrations of this phenomena. An attempt has also been made to point out that biological clocks may well be far more than curious novelties and may be of considerable importance in the study and treatment of serious clinical disease states.

Richard G. Hutchinson, M.D.

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"From Little Acorns"

IN 1957 representatives of the Georgia Hospital Association and the Medical Association of Georgia discussed the possibility of working together in the area of hospital and medical staff relationships. Out of this discussion the need for cooperative action on two major items was clearly recognized. It was agreed that an accreditation service should be initiated for Georgia's smaller hospitals of under 25

beds, as these hospitals were not eligible for accreditation under the national program of the Joint Commission on Accreditation of Hospitals. And it was recommended that a special consultation service should be established to mediate misunderstandings between the hospital trustees, hospital administrator and the hospital medical staff.

To carry out these objectives, the Georgia Hospital-Medical Council was formed in 1958 and is

now sponsored and supported by 13 voluntary medical and health organizations. The Council developed a manual of "Standards For Small Hospitals In Georgia" which is patterned after that of the Joint Commission, but is especially designed and practical for the smaller hospitals. A system for accreditation scoring has been devised, making use of voluntary inspection teams, each composed of one physician and one hospital administrator. Hospitals meeting the Council's minimum standards are awarded certificates of accreditation for specific periods of time.

As its second function, the Council has developed a special consultation service which provides a selected committee of advisors to assist in matters pertaining to medical staff-administrator-trustee relationships. This service is available at any time on request by all three elements of a hospital's organization. The Council has assisted many hospitals with local problems and has been presently requested to study the contractual and professional relationships between hospitals and radiologists in Georgia. As a part of this consultation service, the Council will report its conclusions on this problem during the current year after investigation, conducting hearings and evaluation of their findings.

Responsible Function

In 1961 as an adjunct to these programs, the Council agreed to perform a responsible function for the State Department of Family and Children Services in its Old Age Assistance (Kerr-Mills Law) medical care program. Hospitals of all sizes in Georgia,

which are not nationally accredited, are inspected by the Council on request and a report made outlining recommendations as to acceptance of the hospital for participation in the state OAA program.

And in 1963 the Georgia Hospital-Medical Council undertook a statewide program of nursing home inspection and accreditation. The Georgia Association of Nursing Homes requested the Council establish standards for nursing homes in Georgia under a program similar to the hospital accreditation program and requested Council membership. The Council voted favorably on these requests in line with its objective of stimulating better patient care in our state. It is believed that this nursing home program can be initiated within the next six months.

Five Short Years

Thus in five short years this Hospital-Medical Council has inspected over 50 hospitals; accredited some 20 hospitals; mediated six problems in the hospital-medical field; served in assisting with the State OAA program—and now is planning a program of nursing home accreditation. Inquiries about the Council's activity have been received from 16 states, and two states have used the Georgia Council as a model in activating similar programs. The Joint Commission has lauded this organization; state agencies have recognized its contribution. MAG is proud to be one of the 13 member organizations of the Council which is now "a large Oak tree" in medical hospital health care.

Halothane (Fluothane)

CONSIDERABLE ATTENTION is being given in medical literature and in other forms of press communication to the possibility that Halothane (Fluothane) may be responsible for the production of central hepatic necrosis leading to death from liver failure following either single or multiple administration of the drug. The relative importance of this possibility is difficult to assess and for this reason, a study has been instituted by the National Institute of Health in order to assess the real status of this apparent problem. The possibility of this occurrence was recognized when Halothane was first introduced into

anesthesia, and at that time exhaustive and seemingly adequate studies indicated that no liver damage ensued even after multiple usage of the agent. In recent months, at least 15 cases of "documented" liver necrosis following Halothane administration have been published. Undoubtedly all of such occurrences have not been published or possibly have not been thought to be associated with the administration of this drug. The picture is complicated in some cases by the concurrent presence of biliary tract disease or the administration of other drugs which have the capability of producing liver damage.

When Halothane was first introduced, one anesthesiologist commented that, "if Halothane had been introduced at the time of chloroform and chloroform at the time of Halothane, we would now be using chloroform in much the same manner." This drug may be employed in a number of different combinations. First, it may be used with oxygen as a sole anesthetic agent. Secondly, it can be administered in moderate amounts with varying concentrations of nitrous oxide; in other words, as a complement to light nitrous oxide anesthesia. The third manner of its use is purely as a supplement to nitrous oxide, using this latter agent in concentrations greater than 50 per cent and consequently, finding it necessary to employ only very small amounts of Halothane.

Use

It is this author's preference that this drug be used in the latter circumstance, and it is under these conditions that the major use of this drug has been employed in our institution. We have not personally had the problem of jaundice or liver failure following Halothane anesthesia and possibly this may be the reason. Of course, there is always the possibility that this is a gene related phenomena, a thesis which is becoming more and more applicable to clinical situations that defy explanation from other standpoints. The gene theory would probably explain why this phenomenon occurs only rarely (estimated one in two million administrations) rather than with greater frequency. This same problem may apply to the liver necrosis produced by chloroform which has long been documented and yet follows no definable pattern. This would mean that if a patient had improper gene structure, the administration of even small amounts of an agent for which the body had no protective mechanism could produce fatal consequences.

What then would be advisable in the use of Halo-

thane for anesthesia? It is our opinion that this drug should be used sparingly, strictly as a supplement to other agents. It should never be employed where liver damage is suspected or is likely to occur. Rarely is it necessary to utilize a concentration of Halothane greater than one per cent when sufficient quantities of nitrous oxide are employed. Induction may require slightly higher percentages, although if one is reasonably patient, induction can be accomplished with a one per cent concentration of the drug. In actual practice we find that using the drug in this manner requires a setting of less than half of one per cent of Halothane which should be negligible from the standpoint of toxicity. This would not answer the problem if this is a gene related phenomenon. Now that so much publicity has been given to the agent, it would be quite interesting to note how many cases are reported which heretofore may have been attributed to other causes or may simply have been overlooked because of the lack of a desire to consider a causal relationship in regard to an agent which has found a particular usefulness in the hands of anesthesiologists and anesthesists unwilling to utilize other agents which are non-explosive and which can achieve the same degree of surgical usefulness.

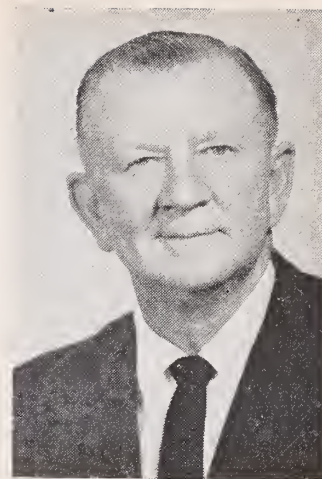
Hazards

No anesthetic is without its hazards. The primary hazard in any anesthetic technique or drug is the knowledge and capability of the individual administering same. If it is established that the amount of Halothane or the number of administrations is a factor in the production of liver damage, then this statement will remain valid. However, should it be found that this is a gene related phenomenon, certain studies will have to be carried out on each patient before Halothane or any other agent is employed on a patient in order to remove *completely* the hazard of inborn errors in gene structure. It is hoped that time and talent will give us a guide before a useful agent is condemned or before a lethal agent is allowed to continue in usage.

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GEORGE R. DILLINGER, M.D.

MEDICAL SCHOOL SCHOLARSHIPS

THE 1951 GEORGIA General Assembly enacted the law creating the State Medical Education Board. The Board was activated in 1953, for the purpose of granting scholarships to medical students.

Medical school scholarships are granted primarily on the basis of need, to those students who agree upon completion of their medical education, to practice in a community of a population of 5,000 or less or to practice at Milledgeville State Hospital. The terms of the scholarship provide that up to \$5,000.00 will be paid to a recipient or \$1,250.00 for each of four years spent in medical school.

The scholarship grant may be repaid as follows:

1. The full amount of the loan may be repaid to the state of Georgia in cash in full with four per cent interest. Payments are to be made annually.
2. The student may repay the loan in services by practicing his profession at some place within the state of Georgia to be approved by the State Medical Education Board.

Credited Loan

One-fifth of the loan, together with interest thereon, shall be credited to the student for each year of practicing his profession in the designated community. No annual interest on the loan shall be paid during such practice or service. After the fifth full year of practice the student shall be relieved from further obligations under his contract.

The purpose and intent of the law is to bring about an adequate supply of M.D.'s in the more sparsely populated areas of the state of Georgia.

At the meeting July 17, 1963, of the State Medical Education Board, 36 new scholarships were granted. Ninety-eight scholarship recipients were already enrolled in medical schools. Twenty-four recipients were in residence training. Twenty-three loan recipients were in the process of entering practice in communities approved by the board. Nine scholarship recipients requested permission of the board to repay in cash with interest. Thirty-one recipients are serving their internship during 1963-1964. Thirty-

six scholarship recipients are presently serving in the armed forces. Seventeen scholarship recipients are in the process of repaying the loan in cash. Fifty-four physicians are now repaying their loans by practice in board approved communities. Thirty physicians completed their contracts in 1962-1963. Six students who withdrew from school repaid loans in full with interest. Eight students withdrew from school in 1962-63.

Instances

In only two instances since the start of the program has the scholarship loan been lost to the state of Georgia. One recipient died during his internship, and one physician left the state and to date has not been located.

Over 90 per cent of the scholarship recipients have served in board approved communities, to repay the state. Thus the program is fulfilling the intent of the law, by providing physicians for the smaller communities in Georgia.

Tribute

I must pay tribute to the Secretary of the Board of Regents of the University System, Mr. L. R. Seibert, and his efficient secretaries. Without their complete study and investigation, it would be impossible for the State Medical Education Board to function with the dispatch and efficiency that it does.

The total cost of operation is about four and one half per cent of the annual budget, for all expenses.

I know of no program which is operating so efficiently and better accomplishing its purpose in the field of medical education.

The present board is composed of J. Hubert Milford, M.D., Chairman; John N. Shearhouse, M.D., Edward K. Russell, M.D., Thomas W. Goodwin, M.D., and George R. Dillinger, M.D.

A handwritten signature in dark ink, reading "George R. Dillinger". The signature is fluid and cursive, with a large, stylized initial 'G'.

President, Medical Association of Georgia

1963-64 CALENDAR OF MEETINGS

State

- September 20-21—Georgia Heart Association, Fifteenth Annual Meeting and Scientific Sessions, Biltmore Hotel, Atlanta.
- September 26-27—Symposium on the Management of Retinal Detachment sponsored by the Department of Ophthalmology, Emory University School of Medicine, Fulton County Medical Society's Academy of Medicine, Atlanta.
- September 30-October 4—"Five Days of Internal Medicine," sponsored by the Department of Medicine, Emory University School of Medicine, Atlanta.
- October 9—"Psychosomatic Medicine Conferences" sponsored by the Department of Continuing Education, The Medical College of Georgia, Augusta (12 weekly sessions).
- October 17-19—Emory Postgraduate Seminar in Gynecology and Obstetrics offered by the Department of Gynecology and Obstetrics, Emory University School of Medicine, Atlanta.
- October 22-24—"Fractures in General Practice" sponsored by the Department of Continuing Education, The Medical College of Georgia, Augusta.
- December 5-6—Fifth Annual Postgraduate Course in Ophthalmology of the Emory University School of Medicine, Grady Memorial Hospital, Atlanta.
- January 14-16, 1964—"Thirteen Cardiacs" sponsored by the Department of Continuing Education, The Medical College of Georgia, Augusta.
- May 3-6, 1964—110th Annual Session of the Medical Association of Georgia, Macon, Ga.**

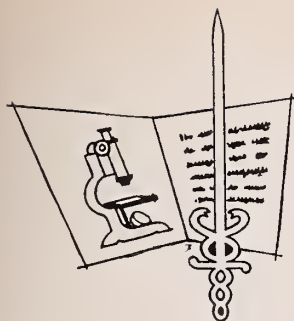
Regional

- October-November, 1963—Postgraduate Courses offered by the Department of Continuing Education of the University of Tennessee Medical Units: October 9-11—"Endocrinology—Diagnosis and Treatment;" October 28-29—"Pediatric Hematology;" October 30-November 1—"Allergy;" November 6-8—"Emergency Surgery—Acute Injuries."
- September 30-October 1—Tennessee Valley Medical Assembly, Read House, Chattanooga, Tenn.
- October 6-9—Medical Society of Virginia, Roanoke Hotel, Roanoke, Va.
- October 8—Special Conference on Oral Cancer, Hotel Fontainebleau, Miami Beach, Fla.
- October 10-13—American Society of Maxillofacial Surgeons, Sheraton-Park Hotel, Washington, D. C.
- October 13-18—International Congress of Plastic Surgery, Sheraton-Park Hotel, Washington, D. C.
- October 14-18—Postgraduate course sponsored by the American College of Chest Physicians on Recent Advances in the Diagnosis and Treatment of Disease of the Heart and Lungs, Washington, D. C.
- October 17-19—Symposium on Orthopedics, Trauma, Minor Surgery, and Office Orthopedics, Mound Park Hospital Foundation, Inc., St. Petersburg, Fla.
- October 20-23—American College of Gastroenterology, Shoreham Hotel, Washington, D. C.
- October 27—Association of Clinical Scientists, Statler-Hilton Hotel, Washington, D. C.
- November 7-9—Conference on Obstetric, Gynecologic, and Neonatal Nursing sponsored by District Four, Washington, D. C.

- November 8-9—Southern Society for Pediatric Research, St. Jude Hospital, Memphis, Tenn.
- November 17-18—Twentieth Annual Meeting of The Southern Chapter of the American College of Chest Physicians, Monteleone Hotel, New Orleans, La.
- November 18-21—Southern Medical Association, New Orleans, La.
- December 10-12—Southern Surgical Association, The Homestead, Hot Springs, Va.
- January 5-8, 1964—First Annual Postgraduate Seminar in Anesthesiology sponsored by the University of Miami and University of Florida Schools of Medicine, Miami Beach, Fla.
- January 13-17, 1964—Postgraduate course sponsored by the American College of Chest Physicians on Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, Miami Beach, Fla.
- January 27-29, 1964—American College of Surgeons, Lord Baltimore Hotel, Baltimore, Md.

National

- September 15, 1963-June 15, 1964—Nine month tutorial program in Cardiology offered by the Institute for CardioPulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.
- September 16-28—Postgraduate course in Laryngology and Bronchoesophagology sponsored by the Department of Otolaryngology, University of Illinois College of Medicine.
- October 5-9—American College of Surgeons 50th Annual Clinical Congress, Conrad Hilton Hotel, Chicago, Ill.
- October 5-11—Annual Otolaryngologic Assembly sponsored by the Department of Otolaryngology of the University of Illinois College of Medicine and the Illinois Eye and Ear Infirmary.
- October 17-19—Clinical Neuropsychiatric Association, Sheraton-Lincoln Hotel, Houston, Tex.
- October 21-22—American Cancer Society, Scientific Session, Conference on Unusual Forms and Aspects of Cancer in Man, Biltmore Hotel, New York City.
- October 21-25—Postgraduate course sponsored by the American College of Physicians on Clinical Cardio-Pulmonary Physiology, Chicago, Ill.
- October 24-30—Association of American Medical Colleges, Sheraton-Chicago Hotel, Chicago, Ill.
- November 11-15—Postgraduate course sponsored by the American College of Chest Physicians on Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, New York City.
- November 18-20—Tenth Symposium, "Aging of the Lung: Perspectives," sponsored by the Hahnemann Medical College and Hospital, Sheraton Hotel, Philadelphia, Pa.
- December 1-4—American Medical Association Clinical Meeting, Memorial Coliseum, Portland, Ore.**
- January 6-March 14, 1964—Ten week Postgraduate Course in Tropical Health sponsored by the Stanford University School of Medicine, Stanford Medical Center, Calif.



THE CLINICAL DIAGNOSIS OF OVARIAN MALIGNANCIES

John R. McCain, M.D., *Atlanta*

MALIGNANCIES of the ovary constitute one of the major gynecologic problems. The incidence of ovarian malignancy is less than that of malignancy of the cervix or of the uterus, but ovarian malignancy forms a disproportionately greater cause of death from cancer among women because of its relatively low five year survival rate. The five year survival rates for the genital malignancies may be remembered by a simple, and reasonably accurate, comparison: for invasive carcinoma of the cervix it is 40 per cent; for carcinoma of the body of the uterus it is nearly 80 per cent; for carcinoma-in-situ of the cervix it is nearly 100 per cent; but for malignancies of the ovary it is only 20 per cent.

Examination

At a pelvic examination the finding of an ovarian enlargement suggests the possibility of a malignancy. All clinically palpable cysts before the menarche or after the menopause are to be considered neoplastic and possibly malignant. During the reproductive years of a woman's life, functional cysts are far more frequent than neoplastic ones. During these years 95 per cent of the cysts five cm. or less in diameter are functional. A neoplasm, possibly malignant, should be the clinical diagnosis if infiltration of the surrounding tissues is found, or if the cysts of this size persist for five months. Ovarian cysts over five cm. in diameter should be considered neoplastic even though a few of these during the reproductive years will be found to be functional.

Solid enlargements of the ovary at any age are considered neoplastic. Malignancy is present in about 65 per cent of the solid tumors of the ovary as compared with an incidence of malignancy of only ten per cent in cystic neoplasms of the ovary. Surgical intervention is indicated at any age if a solid tumor of the ovary is found.

The differential diagnosis of ovarian neoplasms

should include pelvic inflammatory disease, endometriosis, and malignancy of the rectosigmoid. The patient's history, physical signs and laboratory data provide aids in differentiation. Pelvic inflammatory disease is rarely seen before the menarche or after the menopause (or during pregnancy) except as a complication of intestinal pathology. Symptomatic endometriosis is seldom seen in the postmenopausal patient. Malignancies of the rectosigmoid occur almost as frequently as ovarian malignancy in women after 40 years of age. In women over 40, especially if the pelvic mass is in the left adnexal region, preoperative diagnostic studies should include a sigmoidoscopic examination and a barium enema. In preparation for surgery a preoperative radiologic examination of the chest is desirable, especially in postmenopausal patients, to rule out metastatic pulmonary spread.

The clinical evaluation of an ovarian neoplasm at the time of surgery is important, as it may modify the procedures undertaken. As soon as the peritoneal cavity has been opened at an abdominal operation for gynecologic pathology (other than for infection or for hemorrhage) the upper abdomen should be explored for possible abnormalities, including metastatic nodules. After the examination of the upper abdomen has been completed, the pelvic organs may be palpated. The presence of a possible ovarian malignancy is suggested by the presence of bloody ascitic fluid, by bilateral ovarian neoplasms, or by papillary projections through the capsule of the ovary.

Examination of Tumor

If a pathologist is not available, the surgeon himself should examine the ovarian tumor at the time of its removal. His examination should be performed away from the operating table and should be followed by a change of gown and gloves to avoid the possible implantation of neoplastic cells in the operative site. At the examination by the surgeon of an

CANCER PAGE / Continued

ovarian cyst, the presence of hair or teeth within the cyst indicates a dermoid cyst with a very low incidence of malignancy. If a mucus-like fluid is found, the cyst is probably a pseudomucinous cystadenoma which has an incidence of malignancy of five per cent. The presence of serous fluid indicates the likelihood of a serous cystadenoma and, if papillary growths are found within the cyst cavity, the incidence of malignancy is approximately 50 per

cent. Solid tumors, especially ones that are "fleshy" or friable at examination, are associated with a high incidence of malignancy.

The early recognition of the presence of an ovarian neoplasm and the proper evaluation of it regarding possible malignant changes should permit the surgeon to plan a more successful course of therapy for the patient.

384 Peachtree Street, N.E.

Approved by the Professional Education Committee, Georgia Division, ACS.

DOCTORS ATTACK NUMBER ONE EPIDEMIC

A resident physician in a small middle Georgia hospital wearily returns to his desk after administering emergency treatment to the victim of an automobile accident which occurred on U. S. 41 just beyond the city limits of the town in which the doctor lives and works.

The cause of the accident? Probably driver fatigue—fortunately this time no serious injuries.

The doctor looks at a form — another form — given to him by the state patrolman who brought in the accident victim.

Another form? More endless statistics to be fed into computers, categorized and forgotten?

Not quite! The information the physician, and others like him, records takes less than five minutes to supply. From an accumulation of this and similar information supplied in the past have come such life-saving automobile safety features as seat belts, padded dash boards, recessed steering wheel posts, redesigned and strengthened door locks, padded sun visors.

In December, Cornell University's Automotive Crash Injury Research, (A.C.I.R.) working with the Medical Association of Georgia, the Georgia State Patrol, the Georgia Hospital Association and the Georgia Department of Public Health, begins the second field research project in Georgia. The first A.C.I.R. study ran from June 1957 to June 1959.

The project, which will last for two years, works like this: four quadrants of Georgia, based on State Patrol troop areas, will be studied for six months each. The study will begin on December 1 in Troop Area D, with headquarters in Athens. The following six month studies will be in Area B — Albany, Area C — Reidsville, Area A — Canton.

At the time of an injury-producing accident, involving a passenger car of the last four year models and occurring beyond the limits of a municipality, the investigating state patrolman completes a form on the cause of the accident. Only accidents which produce an injury or fatality and which are investigated by the State Patrol are within the scope of the study. The patrolman's responsibilities include taking photographs of the accident. If necessary, camera equipment will be supplied by A.C.I.R.

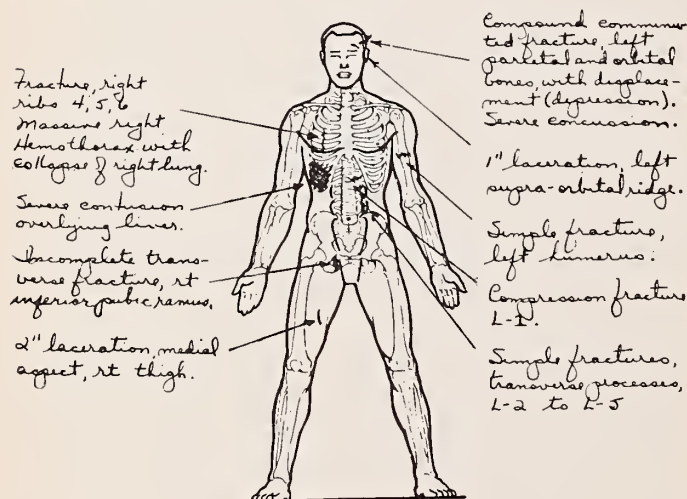
The investigating patrolman supplies a special A.C.I.R. medical report form to the attending physician or the emergency room supervisor of the hospital to which the victim is removed. A medical report form is submitted for each injured person.

Reports and photographs submitted by the investigating patrolman are reviewed for completeness at Troop Headquarters and forwarded to the Georgia Department of Public Health in Atlanta.

The Health Department, functioning as medical coordinator for the project, matches reports from attending physicians with those submitted by the State Patrol and sends the complete package to Cornell University. Doctors are supplied with stamped, self-addressed envelopes to facilitate quick submission of medical reports.

The continuing Cornell study, sponsored nationally by the Automotive Manufacturers Association and the U. S. Public Health Service, has been given vigorous local support in Georgia and has been approved by the Medical Association of Georgia. Data acquired from physicians are treated as privileged medical information, and Cornell's technical staff is available for consultation if any local projects are suggested by the A.C.I.R. study.

Hopefully from this information will come safer highways and safer automobiles that travel these highways in Georgia and across the nation.



Comminuted fracture, right occipital.
2" deep avulsion laceration, right buttock.

NOTE: THIS FORM DEVELOPED BY AUTOMOTIVE CRASH INJURY RESEARCH OF CORNELL UNIVERSITY.

Basic research document is A.C.I.R. physician's form.



THE DIAGNOSIS OF INTERATRIAL SEPTAL DEFECT

James B. Minor, M.D., *Atlanta*

INTERATRIAL SEPTAL DEFECT is one of the most common forms of congenital heart disease and accounts for approximately 20 per cent of all cases.

Embryological Derivation

Though derived from an embryological basis, a simple classification for defects of the atrial septum can best be related to their anatomical location. If one divides the atrial septum into equal thirds, then defects of the upper, mid and lower are termed sinus venosa, ostium secundum and ostium primum defects respectively. Rarely, the entire atrial septum may be absent and a three chambered heart exist (cor tri-louclure biventriculare). In the ostium primum type of defect, one or both of the atrioventricular valves may be involved, and insufficiency of the mitral, and less commonly the tricuspid valve, may be produced. If in addition there is absence of the ventricular septum, a common atrioventricular canal is formed and this is termed atrioventricularis communis.

Abnormal Physiology

Since normally the mean pressure in the left atrium is higher than the right, the abnormal physiology in the uncomplicated atrial defect is the recirculation of arterial blood through the lungs. This increased flow of blood, through the right heart, will of necessity increase the work of both the right atrium and the right ventricle.

Symptoms in general are determined by the size of the defect and by the state of the pulmonary vascular bed (arteriolar resistance).

If the atrial defect is small, there may be no symptoms and no interference with a normal or even long life span.

If the defect is large and the pulmonary vascular bed is normal (low resistant lungs), the pulmonary blood flow may increase from the normal four to six liters per minute to eight to twenty liters per minute with little or no change in pressure. Under these conditions breathlessness, exertional dyspnea, easy

fatiguability, weakness and palpitation are common. Further, the increased lung vascularity provides an ideal culture media and pulmonary infections are frequently encountered. The associated reduction in the systemic blood flow may be sufficient to interfere with both growth and nutrition.

Recognizable Cyanosis

Since under the above conditions the movement of blood is from arterial to venous, recognizable cyanosis is usually absent throughout most, or all, of the course of the disease.

Late or terminal cyanosis (usually occurring in the third decade) may appear when the pulmonary arteriolar resistance has increased sufficiently to elevate the pressures in the right heart and reverse the left to right atrial shunt (high pressure lungs).

In lesions involving the ostium primum where other structural deformities coexist and in the three chambered heart, all symptoms occur earlier and cyanosis may be present from birth.

Complications

The complications of atrial septal defect are many and include anomalous pulmonary venous drainage, pulmonary thrombosis, cardiac arrhythmia (especially atrial flutter) and atrial fibrillation and anomalies of the left heart. Eventually, if uncorrected, the clinical course is usually terminated by right and/or left heart failure.

On auscultation, the diagnosis of atrial septal defect should be suspected when a systolic murmur is found over the second or third left interspace in association with a triple rhythm.

The loudness of the systolic murmur is variable and may be insignificant or accentuated. Since the murmur is produced by the increased flow of blood in the pulmonary artery and since this continues throughout systole, there are no special identifying characteristics other than the murmur starts after the first sound being high frequency, and when re-

HEART PAGE / Continued

corded, usually is in the 70-250 cycles per second range.

Splitting of the pulmonic second sound which is so characteristic to the atrial septal defect produces the triple rhythm. When the second sound shows fixed splitting (constant throughout the respiratory phase) it is even more significant.

An accentuated first heart sound at the apex is frequently encountered in the uncomplicated atrial defect. In the ostium primum cases where organic mitral insufficiency exists, the first sound may be diminished by the systolic murmur, thereby suggesting the association.

An apical diastolic murmur may be present in approximately one third of all cases, and this has been explained on the basis of relative tricuspid stenosis secondary to the increased blood flow.

Electrocardiogram

The electrocardiogram (normal in 10-15 per cent) is most helpful in the diagnosis. The usual configuration is that of right axis deviation in the standard lead (S_1 , R_3) and the RSR prime, but occasionally a tall R in the chest leads (V_1 and V_2). Not infrequently the P waves are more prominent especially in V_1 suggesting atrial enlargement.

Spatial vectorcardiography has done much to clarify the electrocardiographic changes and presents a diagnostic separation between the ostium primum and secundum lesions. In the former, the QRS forces

are predominantly superior and in the latter, by in large inferior. In the electrocardiogram the superior forces present as left axis deviation (R_1 S_3) and as an S wave in the augmented lead AVF.

On radiologic examination the main pulmonary artery and its branches are prominent and on fluoroscopy the vessels pulsate vigorously. The aortic knob is small and the overall cardiac size is moderately to markedly increased.

Additional Examination

Once the diagnosis has been entertained, additional examination including cardiac catheterization and selective angiocardiology are useful not only in the confirmation but also in the selection of patients for corrective surgery.

It is generally agreed that the patient undergoing surgery should have a significant left to right shunt and a pulmonary blood flow of at least twice the systemic flow. On the other end of the scale, when the pressure is sufficiently high to balance the shunt, surgery is contraindicated.

The method of choice for surgical closure today is by direct vision utilizing the pump oxygenator. The expected mortality from ostium secundum or sinus venosa lesions is sufficiently low and less than five per cent. However, with the ostium primum it is much higher and approximates 25 per cent. It would seem logical that surgery should be deferred in the latter cases provided symptoms are absent or mild and the systolic pressure in the pulmonary artery is less than 50 millimeters of mercury at rest.

384 Peachtree Street, N.E.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

INDEPENDENT NON-PROFIT ATLANTA HOSPITALS PRESENT SEMINARS

The Independent Non-Profit Hospitals of Atlanta—Georgia Baptist, Piedmont and St. Joseph's Hospitals, continue to present seminars covering the Fundamental Mechanisms of Disease. Sponsored by a grant-in-aid from the Merck Sharp & Dohme Post Graduate Education Program; E. R. Squibb & Sons; Smith, Kline & French Laboratories; and Pfizer Laboratories, the programs are held on Sunday afternoons from 1:30 p.m. to 5:30 p.m. at the Auditorium, Academy of Medicine, 875 West Peachtree St., Atlanta.

The remaining programs will continue through the fall into December.

October 13—"Early Care of the Premature Infant" Ivan Brown, M.D., Duke University

November 10—"Physiology of Aging" R. H. Dovenmuhle, M.D., Duke University

December 8—"Medical Radiation" C. Craig Harris, M.S., Oak Ridge, Tennessee

All physicians and interested para-medical personnel are invited. There is no registration fee.



MEDICAL REPORTS IN ADMINISTRATIVE PROCEEDINGS

Francis Shackelford, *Atlanta*

AT A RECENT meeting of the Council of The Medical Association of Georgia, an interesting question was asked, the answer to which deserved broader coverage.

Prepared Reports

Medical doctors often prepare reports for either patients or their employers in connection with claims for Workmen's Compensation and in other administrative proceedings in the state. Physicians should remember that the giving of reports and testimony relative to such examinations should be attended with the same care as reports and testimony in trials before a court.

Although the files of administrative boards are usually confidential, the medical doctor's report and testimony can be published in one of several ways. For example, his deposition can be taken by either of the parties to the proceeding. The board's award or denial of an award may have a textual ruling which mentions the medical findings. The record on appeal will almost certainly have the physician's testimony set out in full. As set out in the Georgia Code, these records are open to claimants in some circumstances:

"The records of the Board, insofar as they refer to accidents, injuries, and settlements, shall not be open to the public, but only to the parties satisfying the Board of their interest in such records and the right to inspect them."

Finally, the opinion of an appellate court after an appeal may well make reference to the medical findings. Often appellate courts summarize the factual background at the beginning of their opinions.

Thus, even though the physician may have testified in the presence of attorneys and without his patient having been present, all of what he said, or some partial reference to it, may be set out in some public place at a later time where the claimant may see it in full. The implications are obvious.

The implications can be illustrated by reference to the opinion of the Court of Appeals of Georgia in

a 1957 case. There the plaintiff sued an apartment house because he had fallen down its steps. The defense counsel did a very thorough job of preparation and discovered a letter in the file of the U. S. Employees Compensation Commission dated October 3, 1938, nearly 20 years before, signed by someone who put "M.D." after his name, to the effect that the plaintiff was a malingerer. The implications of such a statement to the claimant in a particular proceeding may well be clear. The effect may linger on for many years.

The Truth

Any medical doctor testifying in any kind of proceeding will obviously want to tell the truth, the whole truth, and nothing but the truth. He will obviously also want to say that the claimant is a "malingerer" if that is his honest opinion. However, it should be remembered that to the injured claimant's ears the word "malingerer" sounds inflammatory. The diagnosis of malingering, if it is a diagnosis, is at best somewhat controversial. Of course, a physician may well find himself using language which is even more colorful.

It should be remembered that confidential communications of patient and doctor in Georgia are not privileged unless the doctor is a psychiatrist. Of course, the privilege would not exist anyway if the physician is employed by the employer or someone other than the patient.

Chance for Publicity

It would be wrong to suggest that a physician would change his testimony in any way because of the possible consequences of publicity of what he says. However, it is also wise to suggest that the medical doctor always remember that his testimony in administrative proceedings is exactly like the testimony he would give in court—subject to full publicity and careful scrutiny in print months, and even years, later.

Suite 1226
C&S Bank Building

Prepared at the request of The Medical Association of Georgia. Mr. Shackelford is a member of the firm of Alston, Miller & Gaines, General Counsel of The Medical Association of Georgia.



EVOLUTION IN MENTAL HEALTH

Charles R. Smith, M.D., *Columbus*

SINCE WORLD WAR II, but more especially in the past decade, developments in the fields of mental health and the treatment and management of mental illness have been among the most dramatic events in the evolution of medical practice. The advent of the ataractic and anti-depressant drugs has stimulated a rapidly changing concept of mental illness, both in the medical profession and the public at large. A new spirit of optimism and hope has at least partly replaced the former stereotype of custodial care and gloomy prognosis. Much of the stigma formerly associated with mental illness and psychiatric treatment has disappeared, although much still remains. The very considerable increase in the number of psychiatrists in private practice, and an increasing identification of psychiatry as an integral part of the mainstream of medical practice, has been a powerful stimulant in the change in public and medical attitudes.

Increasing Maturity

The Mental Health Associations have shown an ever increasing maturity of concept and action, and have evolved largely into groups of public-spirited citizens, rather than individuals whose main motivation was personal or family emotional problems. The Georgia Psychiatric Association, which is the Georgia District Branch of The American Psychiatric Association, was organized to provide for increased communications between psychiatrists in the state, in a common effort to further these changes, and to work toward improvement of mental health and psychiatric treatment facilities in the state. Organization of the Association was in part stimulated by Judge Frank Smith and the Mental Health Association of Georgia, and a close liaison between the Mental Health Association of Georgia and the Georgia Psychiatric Association has existed since. These joint efforts were important in establishing the unique Intensive Treatment Program of the Georgia Department of Public Health and the eventual transfer of

Milledgeville State Hospital and Gracewood to the Georgia Department of Public Health, with consequent progress in improving the quality of services in these institutions.

Insurance Coverage

The past few years have also seen an increasing coverage of mental illness by many hospital and medical insurance plans operating within the state. This has stimulated the development of more treatment of mental illness in general hospitals nearer the patients' homes, providing a more rapid recovery, and of patients returning to a functioning, productive life in their communities.

The Departments of Psychiatry at both The Medical College of Georgia and Emory University School of Medicine are well on the way in developing very comprehensive training programs which should eventually adequately supply the needs of the area for more psychiatrists. Area training facilities for related professional personnel, including Clinical Psychologists, Psychiatric Social Workers, Psychiatric Nurses, etc., are also being developed at an encouraging rate.

Integrity of Private Practice

We, as members of the Georgia Psychiatric Association, intend to continue to work toward the further improvement of psychiatric treatment and the Mental Health Program in the state of Georgia, including the establishment of more adequate follow-up treatment of patients furloughed or discharged from Milledgeville State Hospital. At the same time we wish to exert every effort toward maintaining the integrity of our American system of private practice of medicine, in that we feel this offers the highest possible caliber of service to patients. We must be vigilant in preventing the well-meant but insidious trends toward the socialization of medicine that constitute a threat, not only in Georgia, but throughout the entire United States.

Dr. Smith is President of the Georgia Psychiatric Association.

1953 Seventh Avenue

Prepared at the request of the Sub-committee on Mental Health of the Medical Association of Georgia.



PHYSICIAN'S BOOKSHELF

BOOKS RECEIVED

Ryan, Thornell, and von Leden, **SYNOPSIS OF EAR, NOSE, AND THROAT DISEASES**, The C. V. Mosby Co., St. Louis, Mo., 1963, 425 pp., \$7.50.

DeSanctis, Adolph G., M.D., and Varga, Charles, M.D., **HANDBOOK OF PEDIATRIC MEDICAL EMERGENCIES**, Third Edition, The C. V. Mosby Co., St. Louis, Mo., 1963, 457 pp., \$12.75.

Shields, John R. S., M.D., **HANDBOOK OF THE PRACTICE OF ANESTHESIA**, The C. V. Mosby Co., St. Louis, Mo., 1963, 203 pp., \$6.85.

Members of the Sections of Neurology and Section of Physiology, Mayo Clinic and Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota, Rochester, Minnesota, **CLINICAL EXAMINATIONS IN NEUROLOGY**, Second Edition, W. B. Saunders Co., Philadelphia, 1963, 396 pp., \$8.00.

Edited by Postlethwait, R. W., M.D., **RESULTS OF SURGERY FOR ULCERS**, (A Cooperative Study by Twelve Veterans Administration Hospitals), W. B. Saunders Co., Philadelphia, 1963, 308 pp., \$8.00.

Nadas, Alexander S., M.D., **PEDIATRIC CARDIOLOGY**, Second Edition, W. B. Saunders Co., Philadelphia, 1963, 828 pp., \$16.00.

Hinshaw, H. Corwin, M.D., and Garland, L. Henry, M.D., **DISEASES OF THE CHEST**, Second Edition, W. B. Saunders Co., Philadelphia, 1963, 798 pp., \$20.00.

Medical Department, United States Army, **ORGANIZATION AND ADMINISTRATION IN WORLD WAR II**, Office of the Surgeon General, Department of the Army, Washington, D. C., 1963, 613 pp.

Medical Department, United States Army, **SURGERY IN WORLD WAR II, THORACIC SURGERY**, Volume I, Office of the Surgeon General, Department of the Army, Washington, D. C., 1963, 394 pp.

Medical Department, United States Army, **INTERNAL MEDICINE IN WORLD WAR II, INFECTIOUS DISEASES**, Volume II, Office of the Surgeon General, Department of the Army, Washington, D. C., 1963, 649 pp.

REVIEWS

Hughes, James G., M.D., **SYNOPSIS OF PEDIATRICS**, The C. V. Mosby Co., St. Louis, Mo., 1963, 1031 pp., \$19.50.

DR. HUGHES and his group at the University of Tennessee College of Medicine have made a most commendable effort to bridge the gap between oversimplification and infinite detail in existing pediatric text books. That they did not meet with complete success should deter none from obtaining this useful volume. There is a wealth of information available in tables, charts, and unique illustrations, as well as in the text.

The reason for not designing this book as a complete success lies mainly in what the reviewer considers uneven emphasis. Over one-half page is devoted, for example, to means of obtaining a clean catch specimen of urine in the young female, whereas only slightly over three pages are used in discussing prematurity, a condition which triggers some 50 per cent of neo-natal deaths. Nor is the condition even indexed.

The index, incidentally, could be more complete. I could find no reference to hydrocephalus, to polycystic kidney, and several other less common disorders.

Minor fault-finding aside, I consider this a volume which should be exceedingly helpful to any physician whose practice includes infants and children.

Ruskin King, M.D.

Noyes, Arthur P., M.D., and Kolb, Lawrence C., M.D., **MODERN CLINICAL PSYCHIATRY**, Sixth Edition, W. B. Saunders Co., Philadelphia, 1963, 586 pp., \$8.00.

THIS SIXTH edition of a familiar text has been completely revised both in format and contents. The print is larger than in the older editions, and the chapters are divided into subject groupings with bold type for the headings, making it easy to locate the desired information.

The chapter on personality development presents in a condensed form, without sacrifice of clarity, the basic data on personality development essential to understanding psychopathology. The latest concepts of the influences of social, sleep, and sensory deprivation are presented. The chapter on drugs used in treatment of psychiatric patients has been enlarged, giving up-to-date experience with the various agents.

Each psychiatric disorder is discussed by starting with a clinical description followed by method of examination, the most acceptable method of treatment, and prognosis. The clinical descriptions are very colorful, calling up a readily recognizable picture of a patient. Treatment procedures are described in easily applicable fashion.

The text which has been most useful for the medical student offers a very ready reference for the practicing physician who is interested in gaining an understanding of his psychiatric patient and in becoming acquainted with the methods of treatment currently in use.

Joseph S. Skobba, M.D.

Bland, John H., M.D., **CLINICAL METABOLISM OF BODY WATER AND ELECTROLYTES**, W. B. Saunders Co., Philadelphia, 1963, 623 pp., \$16.50.

THIS BOOK is a very complete, up-to-date treatment of the subject of body fluids and electrolytes in disease and health. It is edited and partially written by Dr. Bland, who is well qualified on the subject, having written one of the first books on the subject. The other contributors are also adequate and include such authorities as Arthur Grollman, Francis Moore, and William Meroney.

It is very difficult to be critical of a work that is so complete and up-to-date; however, there are certain points that limit the usefulness of the book. It contains 623 pages, which is too much reading, and as expected, some of the same information is repeated by the various authors. Many subjects which are only indirectly related to the subject are discussed in detail. For example, the minute discussion of heart fail-

PHYSICIAN'S BOOKSHELF / Continued

ure by Dr. Grollman is excellent, but much of it belongs in a text of Cardiology. In the same way a discussion of the hydra, pulmonary function tests, etc., add to the bulk of the volume. In short, the book is too much a textbook of general medicine and its detail makes it more of a reference book. The medical student may not be bothered by this but the busy doctor in private practice may become bogged down. Aside from its bulk, the book is easy to understand and is well indexed and illustrated.

Charles L. Whisnant, M.D.

Silver, Henry K., M.D.; Kempe, C. Henry, M.D.; and Bruyn, Henry B., M.D., **HANDBOOK OF PEDIATRICS**, Fifth Edition, Lange Medical Publications, Los Altos, Calif., 1963, 602, pp., \$4.00.

I HAVE USED an earlier edition of this book while in medical school and in residency training.

Generally the book seems to be an expansion of the earlier editions. As the authors state, this book is not intended to take the place of larger volumes, but does present a concise, well-ordered system of facts about each entity discussed. Of particular value is the section on "Emotional Problems in Pediatrics" which covers quite well problems which may be encountered in practice. The drug section seems very complete. Many late methods of treatment are included and seem well organized.

I believe, since the book is revised frequently, important current references could be included at the end of each section.

This book has a definite place in the armamentarium of every physician who deals with children, or their medical problems.

Stephen S. Redd, M.D.

Warren, Richard, M.D., **SURGERY**, W. B. Saunders Co., Philadelphia and London, 1963, 1397 pp., \$19.50.

DOCTOR RICHARD WARREN's book is a comprehensive textbook for student and surgeon alike. It was written in collaboration with a group of clinicians from Harvard University covering all the surgical specialties.

The subjects covered give the basic essentials and in addition present details, which should appeal to the

experienced clinician. This book, therefore, fulfills a dual purpose in its appeal to both the student and the surgeon.

This text copyrighted in 1963 deals with 1963 surgical problems and treatment. The rapidly developing techniques of vascular surgery and the chemotherapeutic treatment of malignancy are well covered and current.

Surgical technique has been held to a minimum, and though the illustrations are plentiful, they have their limitations in realistically depicting certain conditions.

This is an excellent teaching text and would be a valuable addition to the library of both students and surgeons.

B. A. Addison, M.D.

Hamilton, James Alexander, M.D., **POSTPARTUM PSYCHIATRIC PROBLEMS**, The C. V. Mosby Co., St. Louis, Mo., 1962, 156 pp., \$6.85.

DR. HAMILTON certainly deserves praise for attempting to survey the world literature and, together with comments from his own experience, to present a systematic approach to diagnosis and treatment of such a broad field.

His book is certainly unique in the emphasis placed on the endocrine basis for the cause and for treatment of many of the postpartum psychiatric problems. He cites many examples to show the value of thyroid replacement therapy in the treatment of many of these problems, with rather remarkable results.

By attempting to cover so broad a field, he presents some areas in almost outline form, while other areas are covered in almost too minute detail.

Although the book is intended for the general practitioner, the obstetrician, and other non-psychiatric members of the medical profession, many of the cases presented should obviously have psychiatric care.

The book does not overuse psychiatric jargon and is easy to read, although at times the organization of the material is somewhat difficult to follow.

This book should stimulate interest in these particular problems, and as such, is certainly worthwhile. However, one is left wondering if Dr. Hamilton believes there is any psychological basis for such problems, and it is quite doubtful he has any faith in psychotherapy for their treatment.

Richard E. Felder, M.D.

AMA OFFERING IDENTITY CARDS

Medical identification cards, which physicians may purchase in quantity to give to their patients as a service, are available from the American Medical Association.

The cards, which bear the AMA emergency medical identification symbol (*The AMA News*, June 17, 1963) fit in a billfold and note any special medical problems that need immediate attention in an emergency or potential emergency.

The cards may be obtained from the AMA Order

Dept., 535 N. Dearborn, Chicago 10, Ill. Cost is \$1 per hundred or \$5 per thousand.

The AMA Committee on Emergency Medical Identification has recommended that everyone carry a medical identification card. People with special health problems should also wear an alerting device—wristlet, anklet, dog tag or other device which indicates their need for special care.

Reprinted from the AMA News, August 5, 1963.



ABSTRACTS BY GEORGIA AUTHORS

Bryant, Milton, M.D.; Walter L. Bloom, M.D.; and Spencer S. Brewer, M.D., 384 Peachtree Street, N.E., Atlanta 8, Georgia, "Experimental Study of the Antithrombotic Properties of Dextran of Low Molecular Weight," Am. Surgeon 29:256-260 (April) 63.

The use of clinical dextran in preventing thrombosis in small arteries which have been traumatized has been previously reported from this laboratory. A number of investigators have now confirmed our findings that clinical dextran retards intravascular thrombosis formation and is helpful in preventing postoperative thrombosis in vascular surgical procedures. This report is a continuation study evaluating the effect of dextrans of low molecular weight in preventing thrombosis in small arteries subjected to mechanical trauma.

A standardized preparation in the dog has been used to evaluate the effect of dextrans of low molecular weights in preventing thrombosis in small arteries subjected to surgical trauma. In 23 preparations given an infusion of dextran, with an average molecular weight of 43,000, the two hour thrombotic rate was 50 per cent. The thrombotic rate in 12 preparations treated with NRC-2B dextran, average molecular weight 34,000, was 90 per cent and in ten preparations treated with NRC-2, average molecular weight 11,800, the thrombotic rate was 75 per cent. When these thrombotic rates are compared with a thrombotic rate of ten per cent following clinical dextran infusion, it would appear that dextrans of low molecular weights are not as effective as clinical dextran in preventing intravascular thrombosis.

Naiman, Richard A., M.D., and J. Gordon Barrow, M.D., 47 Trinity Avenue, S.W., Atlanta 3, Georgia, "Penicillin-Resistant Bacteria in Mouths and Throats of Children Receiving Continuous Prophylaxis Against Rheumatic Fever," Ann. Int. Med. 58:768-772 (May) 63.

Since bacterial endocarditis caused by alpha streptococci has been shown to be a particularly serious event in the management of patients with rheumatic heart disease and because infection with penicillin resistant strains of alpha streptococci might well pose a therapeutic problem in treatment, an investigation comparing the mouth flora of three groups of individuals living free in the community was carried out. A total of seventy-four persons were studied, including eight normal individuals and 66 patients of whom 45 were on sulfadiazine prophylaxis against rheumatic fever and 21 were on penicillin prophylaxis. A culture of the anterior tooth-gum margin and a culture of the throat were obtained from each indi-

vidual and the sample planted simultaneously on plain blood agar and agar with two units of penicillin per milliliter. Evaluation of growth and identification of organisms was accomplished according to standard bacteriologic techniques by experienced technicians who did not know from which group the specimen had come.

Eighty-one per cent of the individuals on penicillin prophylaxis demonstrated the presence of alpha streptococci resistant to two units of penicillin per milliliter at one or both sites. No penicillin resistant alpha streptococci were found in any individual in either of the other two groups.

The implications of penicillin resistance to the therapy of bacterial endocarditis are discussed and it is suggested that a large scale study of this disease be undertaken to determine whether or not long term penicillin prophylaxis against recurrent rheumatic fever is a significant problem in the development and prognosis of cases of bacterial endocarditis.

Furst, Stephen E., M.D., 1285 Peachtree St., N.E., Atlanta 9, Georgia, and Edmund A. Dowling, M.B., B. Ch., Birmingham, Alabama, "Intra-Abdominal Hemorrhage Due to Polyarteritis Nodosa," South. M.J. 56:545-457 (May) 63.

Fibrinoid necrosis, the basic pathological process in polyarteritis nodosa, leads to thrombosis and aneurism formation. Thrombosis with resultant infarction of tissue has been commonly reported in this condition, but aneurismal rupture has been relatively infrequently noted.

The observed patient was noted to have symptoms referable to polyarteritis for 15 years. Ten years previously he had a tender, distended abdomen and on laparotomy was noted to have subserosal petechiae. At that time he was diagnosed as having Henoch's Purpura. His terminal episode consisted of massive intrarenal and intra-abdominal hemorrhage due to rupture of an intrarenal artery aneurism. In spite of intensive medical and surgical therapeutic measures, the patient expired. At autopsy, diffuse aneurism formation was noted. There was intra-pancreatic hemorrhage due to aneurismal rupture which had not been previously noted in this condition. In addition, there was fusion of two commissures of adjacent aortic valve cusps without thickening of the cusps.

The association of Henoch's Purpura and fusion of valvular cusps, both of which have been attributed to hypersensitivity, with polyarteritis nodosa adds another shred of evidence to the hypersensitivity theory of the etiology of polyarteritis.

Goldberg, Leon I., M.D., and Zimmerman, Alfred M., M.D., 317 Hertford Circle, Decatur, Georgia, "Guanethidine and Methylodopa as Therapeutic Agents in Hypertension," Postgrad. Med. 33:548-5554 (June) 63.

This paper is a review of pharmacological and clinical studies of guanethidine and methylodopa. The postulated mechanisms of action, clinical efficacy, side effects and toxicity of these agents are discussed. The paper concludes that methylodopa is not as potent as guanethidine, but may control hypertension in certain patients without many of the side effects associated with guanethidine. (62 references).

Bryan, J. A., II, M.D.; Long, V. A., M.D., and McDaniel, G. E., M.D., C.D.C., 1600 Clifton Road, N.E., Atlanta 22, Georgia, "Poliomyelitis—Newberry County, South Carolina," J.A.M.A. 184:631-631 (May 25) 63.

In 1961, Newberry County, South Carolina, reported three times as many cases of poliomyelitis as had ever been recognized in that county. A total of 24 cases caused by type III poliomyelitis virus were reported, 19 occurring during the seven week period following the opening of the Negro elementary school.

The majority of patients studied during the epidemic period were school-aged Negro children, while the remaining patients had had direct contact with either a recognized case or with Negro children of grammar school age.

This age and this racial group had never been previously involved by epidemic poliomyelitis in South Carolina. Although Salk vaccine had been used in this population; only 41 per cent of the school aged Negroes had had three or more doses of the vaccine, and only two of the twenty-four cases which occurred gave this history.

Type III oral polio vaccine was utilized to attenuate the epidemic, but was probably used too late to have appreciable effect.

Scheinberg, Peritz, M.D., Miami, Florida, and Zunker, Ellyn, M.D., 36 Butler Street, S.E., Atlanta 3, Georgia, "Complications in Direct Percutaneous Carotid Arteriography," Arch. Neurol. 8:676-684 (June) 63.

A retrospective study of the charts and X-rays of 500 consecutive patients who had a total of 902 cerebral arteriographic procedures was made in an effort to correlate arteriographic complications with mechanical or disease factors.

Thirty-four serious complications occurred (3.7 per cent of the arteriograms but 6.8 per cent of the patients), including three deaths and five prolonged or permanent cases of hemiparesis.

ABSTRACTS / Continued

Inadequate technique or occlusive vascular disease was found to be associated with the complications in 31 of the 34 patients (91 per cent), whereas in a group of 100 "control" cases in whom no complications occurred and taken from the same series, indications of inadequate technique or occlusive vascular disease could be discovered in only 14 per cent.

In the patients with arteriographic complications there was a history of multiple arterial punctures in 60 per cent of arterial trauma in 60 per cent, or atherosclerotic plaques or occlusion in 26 per cent, and severe vascular spasm in 16 per cent.

The possible role of dye toxicity in the production of complications is discussed, but it is concluded that defects in arteriographic technique and the presence of occlusive atherosclerotic extracranial cerebral vascular disease constitute the major source of arteriographic complications. Suggestions are made for avoiding or minimizing these hazards.

Wight, Robert P., Jr., M.D.; McCall, Marvin M., M.D.; and Wenger, Nanette Kass, M.D., 36 Butler Street, S.E., Atlanta 3, Georgia, "Primary Atrial Tumor," Am. J. Cardiol. 11:790-797 (June) 63.

Primary atrial tumors are now included among surgically correctible cardiac abnormalities. The frequency of sudden death in patients with symptomatic atrial tumors and the unfavorable prognosis associated with incorrect pre-operative diagnosis prompted this review. We attempted to determine which clinical and laboratory findings should raise the suspicion of atrial tumor.

The case records of ten patients with primary atrial tumor were reviewed. In seven cases the tumor was clinically significant, most frequently presenting with signs and symptoms suggestive of mitral valve blockade and right heart overloading. An erroneous diagnosis of mitral stenosis was frequently made.

Useful diagnostic clues for differentiating atrial tumor from mitral stenosis are:

- 1.) a history of syncope,
- 2.) positional change in an apical diastolic rumble,
- 3.) positional change in blood pressure and heart rate,
- 4.) intracardiac calcification not characteristic of mitral valve calcification.

Accurate diagnosis and prompt therapy are mandatory in this group of patients who are prone to sudden death.

Wiggins, Roy A., M.D., 35 4th Street, N.E., Atlanta 8, Georgia, "Observations of the Use of 19-Nortestosterone in Patients with Oliguric Uremia," South M.J. 56:669-672 (June) 63.

For some time the use of androgenic substances has been recommended for patients with acute renal insufficiency. As early as 1891 testicular extracts were reported to create clinical improvement with two patients in renal failure. Freedman and Spencer in 1957 reported metabolic ward studies of testosterone propionate in chronic renal failure. 70 per cent of their patients demonstrated chemical improvement. Recent interest has centered around synthetic androgenic substances.

In the present study three patients with sudden onset of oliguric renal insufficiency and without complicating

clinical considerations were treated with 19-Nortestosterone phenylpropionate (Durabolin). Biochemical data are presented which indicate a slight improvement in the course of illness during a time when the only variation in treatment was the administration of an anabolic agent.

No evidence of drug toxicity was found.

The comment of J. P. Merrill would seem to summarize the proper attitude toward the use of the newer synthetic anabolic androgenic steroids: These compounds are a "definite, but not all important, adjunct to treatment" in acute renal failure.

Norris, Jack C., M.D., 490 Peachtree Street, N.E., Atlanta 8, Georgia, "Let's Take the Fuss out of Pap," South. M.J. (June) 63.

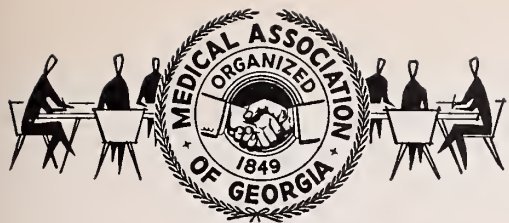
The article briefly refers to historic facts concerning various stains for detecting cancer cells, emphasizing the value of Hematoxylin (Harris) and polychrome methylene blue, (Terry) modification, as being perhaps the most valuable in current use. Also the author suggests that there are ways to make suitable and readable Pap smears by using shorter technical procedures than that of Pap's technique, with the use of Permunt as a covering agent instead of glass coverslips, and finally the article cautions against accepting Pap smears as an absolute diagnostic agent in diagnosing cervical or other forms of cancer, so as not to mislead the doctor or patient into a false sense of security. A simplified report chart is outlined that appears to give sufficient information to the doctor whenever the Pap smears are read. The author also pays high tribute to Papanicolaou for his great contributions to cancer cytology.

ABSOLUTE SAFETY NOT GUARANTEED

By its enactment of the Kefauver-Harris Act last year, Congress placed far-reaching and fearsome new responsibilities on the Food and Drug Administration. Now, we believe that Congress should follow through and provide FDA with the resources it needs to do its new job wisely and well. In the words of John T. Connor, President of Merck & Company — "It would be a senseless tragedy if this nation forfeited its leadership in drug progress, not for lack of discoveries, but because a regulatory agency could not keep pace." . . . But however well the FDA is armed by Congress with human and material resources, none of us should lose sight of the fact that the pathways of scientific research and development are uncertain ones at best, and that no rule or regulation or law can guarantee absolute safety whether in outer space or in the pharmaceutical laboratory or the hospital clinic. — Theodore G. Klumpp, M.D., President, Winthrop Laboratories, to Senate Appropriations Subcommittee, April 4, 1963.

"WHAT'S WRONG" TO "WHAT'S RIGHT"

Today both the role of the physician and the role of the pharmaceutical industry are undergoing rapid and dramatic changes. The public has become generally better informed on medical care, and in many cases its information has been obtained not from the source but from critics of the source. Unfortunately, our "news" consists almost entirely of "what's wrong," because one must assume there is little readership interest in the vastly greater area of "what's right" about life and business. Therefore, both the medical profession and the ethical drug industry have a new challenge: to provide to the public factual information on medicine and medical care without disturbing the important, highly personal, physician-patient relationship. —Francis C. Brown, President, Schering Corporation, to joint conference of the U. S. Food and Drug Administration and the Food Law Institute. November 26, 1962.



THE ASSOCIATION

DEATHS

ISAAC GRANT ARMISTEAD, 75, died at Brunswick July 3, 1963, after an extended illness. Dr. Armistead had resided in McIntosh County since 1925. He was a member of the Baptist Church in Grove Hill, Alabama, and the Masonic Lodge in Waycross. He received his medical degree from the medical school in Mobile, Alabama.

Survivors include his wife, Mrs. Clara Jackson Armistead, Pine Harbor, Georgia; two sisters, Mrs. Annie Laura Potts, Maplesville, Alabama, and Mrs. Marie A. Stallard, Grove Hill, Alabama; and one brother, T. N. Armistead, Lafayette, Georgia.

FRANK K. NEILL, 67, of Albany, died July 7, 1963, at his home after a long illness.

Dr. Neill received his medical degree from Vanderbilt University where he was an All-Southern end on the football team and was nominated for All-American by the late Grantland Rice. He interned at Halstead, Kansas, and served his residency at the Long Island Hospital in Boston. He did postgraduate work at the Lahey Clinic, Boston, and at Tulane University and the University of Colorado.

He was a fellow of the American College of Surgeons, a member of the Southeastern Surgical Association, the American Medical Association, the Southern Medical Association, and the Medical Association of Georgia.

Dr. Neill was a former president of the Dougherty County Medical Society, former chief of staff of Albany's Pheobe Putney Hospital, a member of the board of the Easter Seal Treatment Center, a representative to the Pheobe Putney Hospital Authority, and had served as American representative to several international medical meetings. He retired from active practice last March.

Dr. Neill is survived by his wife, the former Mary Field of Petersburg, Va.; two daughters, Mrs. Tom C. Campbell and Mrs. R. Page Griffin, both of Atlanta; a son, Frank K. Neill, Jr. of New York; a sister, Miss Jean Neill, and a brother, Robert Neill, both of Birmingham, Ala.

ALBERT J. KELLEY, 61, died at Memorial Hospital, Savannah, July 5, 1963 following surgery.

Dr. Kelley was chairman of the Chatham County Board of Health and chairman of the Health and Hospital Planning Commission of Metropolitan Savannah.

He was a former chief of staff at Memorial Hospital and a member of the Georgia Medical Society, American Medical Association, American College of Obstetrics and Gynecology, and the South Atlantic Association. He was also a member of the Oglethorpe Club and the Cotillion Club.

A native of Chicago, Dr. Kelley had lived in Savannah and practiced his specialty here since 1937. He studied medicine at Northwestern University and served for a time as a Navy medical officer.

Surviving are a sister, Miss Helen Kelley; two brothers, Howard C. Kelley of Des Plaines, Ill., and Arthur P. Kelley of Dallas, Tex.; two daughters, Mrs. C. B. Compton of Savannah and Mrs. Calvin Smith of Lambert, Miss.; and two sons, Peter Kelley of Lancaster, S. C., and A. J. Kelly, II of the U. S. Navy.

SOCIETIES

FULTON COUNTY MEDICAL SOCIETY is sponsoring its first Explorer Post in medicine, the first such speciality post in the South. Dr. Walker L. Curtis heads the program and working with him are Dr. Robert Roberts, Dr. Henry E. Steadman, Dr. Steve G. Cline, Dr. W. Ben Davis, Dr. Floyd Davis, Dr. Lewis B. Hasty, and Dr. Hugh Thompson.

Recently elected as President of BLUE RIDGE MEDICAL SOCIETY was Dr. William Tryon of Blue Ridge.

PERSONALS

First District

No news submitted.

Second District

The Moseley Clinic and Hospital, Donalsonville, has recently been purchased by ROBERT J. STARLING. JAKE H. HOLLEY is presently associated with Dr. Starling.

GEORGE R. DILLINGER, Thomasville physician and President of the Medical Association of Georgia, spoke July 5, 1963, to the Thomasville Kiwanis Club. Dr. Dillinger's topic concerned Medicare.

Third District

V. W. MCEVER, JR. has announced the opening of his office at the Warner Robins Clinic, 110 Hospital Drive, Warner Robins, for the practice of surgery.

Americus pathologist, FREDERICK THOMPSON, spoke in July to the Sylvester Kiwanis Club. Dr. Thompson spoke on the role of the pathologist in the community. He is presently President of the Georgia Association of Pathologists.

EDGAR HORN and Mrs. Horn of Columbus entertained June 30, 1963, at a swimming party at their home. The honored guests were the new residents and interns of the Medical Center and their wives.

THE ASSOCIATION / Continued

Fourth District

W. M. DALLAS, JR. and Mrs. Dallas were honored at a reception in Thomaston July 4. Dr. Dallas and his wife have recently moved to the city where Dr. Dallas' office will be located at 118 East Thompson Street for the practice of surgery.

LANIER ALLEN, a native of Valdosta, has joined R. E. DALLAS and W. J. GOWER in the general practice of medicine at the Dallas-Gower Clinic in Thomaston.

Fifth District

"Mental Problems in Industry," was the subject of WINSTON E. BURDINE, Atlanta, when he spoke July 10, 1963, at the noon luncheon meeting of the Atlanta Army Depot Chapter of the Armed Forces Management Association.

MARTON MAJOROS, associated with the Ponce de Leon Infirmary, Atlanta, recently received from the University of Minnesota the degree of Master of Science in Otolaryngology for graduate work done during his residency at the Mayo Clinic.

As of September 1, 1963, JOHN G. LEONARDY will be associated with JOHN S. ATWATER, LAMAR B. PEACOCK, W. HARRISON REEVES, HAROLD A. FERRIS, and C. DANIEL CABANISS in the Doctors Building, Atlanta.

Sixth District

A. M. PHILLIPS, JR., Macon, has announced the opening of his office in the Macon Doctors Building for the practice of orthopedics.

EDSEL DICKEY of Macon left New York July 2 for a month's tour of duty in the middle east country of Jordan. Dr. Dickey's assignment was under the sponsorship of Medico Care. He returned to his private practice early in August.

Seventh District

W. P. CARSON and F. THOMAS CAREY, Chatsworth, recently welcomed JACK R. MEACHAM, a graduate of the Medical College of Georgia, to their offices for the practice of medicine.

FRANK THOMPSON has recently become an associate of CHARLES R. MERRITT in Carrollton. Dr. Thompson is a pediatrician.

JOHN ELLIS, Rossville, spoke in late June to the Walker-Dade-Catoosa Medical Auxiliary. The film

"Operation Hometown," which deals with medical legislation, was shown and Dr. Ellis led a discussion following the film.

DARIUS A. SMITH will enter general practice in Dallas where he will be associated with S. U. BRALY, J. L. WORTHY, and J. M. COVINGTON.

Eighth District

RUSSELL A. ACREE, Hahira, has joined J. R. SMITH and JESSE PARROTT on the physicians' staff of Smith Hospital, Inc. His temporary offices are located in Smith Hospital until the new doctors building is completed where his permanent offices will be located.

Waycross physician, J. DUNCAN FARRIS, attended the Second International Conference on Congenital Malformations held in New York July 14-19.

VILDA SHUMAN, Waycross, has recently been named first Vice President of Pilot Club International. Pilot International, a classified civic and service club for executive business and professional women, held its 42nd annual convention in Miami Beach in July. Dr. Shuman has served in various executive capacities in the organization for several years.

RAY HAMPTON of Augusta is now associated with G. W. BARKER and REX STUBBS at the St. Mary's Clinic in St. Marys. He is also a member of the Gilman Hospital staff.

Now associated with GRADY WILLIAMS in the practice of medicine in Nashville is Y. F. CARTER, JR., a 1960 graduate of the Medical College of Georgia.

Ninth District

On July 1, R. H. CHANEY, JR. and R. E. SHIFLET returned to the Medical Arts Clinic, Toccoa, to resume association with that medical group. Dr. Chaney has been serving a two year residency in anesthesiology at Augusta, and Dr. Shiflet has been on a leave of absence for the past four years taking a urology residency at the University of Pennsylvania.

Tenth District

JOHN T. NORMAN, a native of Lincoln County, has joined JOHN B. O'NEAL and JACK B. HANKS in the practice of medicine in Elberton.

LOUIS SCHARFF of Augusta attended the five day conference in New York of the Second International Conference on Congenital Malformations which was held July 14-19.

MAG EXECUTIVE COMMITTEE OF COUNCIL MEETING

THE JULY EXECUTIVE COMMITTEE of Council meeting was called to order at 4:55 p.m. July 17, 1963, MAG Headquarters Building, Atlanta, Georgia, by the Chairman President George R. Dillinger.

The members in attendance were: George R. Dillinger, Thomastown; J. G. McDaniel, Atlanta; John T. Mauldin, Atlanta; Thomas W. Goodwin, Augusta; Addison W. Simpson, Washington; Walker L. Curtis, College Park; John S. Atwater, Atlanta; and Virgil B. Williams, Griffin. Also present were Dr. R. C. Williams, Medicare Administrator; Mr. Richard Nelson, AMA Field Representative; Mr. Milton D. Krueger, Mr. James M. Moffett and Mrs. Catherine Wooten, MAG Staff.

The invocation was given by Dr. Dillinger.

Reading of Minutes

The minutes of the June Executive Committee meeting and the Council meeting were read by Mr. Krueger. On motion duly made and seconded these minutes were approved as read.

Treasurer's Report

Dr. Atwater gave the Treasurer's report and on motion (Mauldin-McDaniel) the report was approved as presented.

Legal Retainer Fee

Dr. McDaniel and Dr. Mauldin stated that after a meeting with the MAG Attorney, an increase in the retainer fee per annum effective January 1964 was satisfactory with all concerned. On motion (Goodwin-Simpson) it was voted to refer this matter to Council with the recommendation for approval.

MAG Tax Status

Mr. Krueger reported that a letter from the MAG Attorney had been received stating that the case is now in court. Received for information.

Georgia Association of Pathologists Resolution

Dr. Dillinger read a letter from the Georgia Association of Pathologists seeking MAG support of the pathologists' resolution that proper supervision of hospital laboratories by pathologists is necessary. After discussion on motion (Mauldin-McDaniel) it was voted to instruct the President of the Georgia Association of Pathologists that MAG will cooperate in any way that is agreeable to both MAG and the Georgia Association of Pathologists.

Relative Value Fee Schedule Query

Dr. Simpson read a letter from the Fulton County Medical Society regarding the Relative Value Fee Schedule Study. The Board of Trustees of the Fulton County Medical Society requested that no definite action be taken on the dissemination of the results of the study either by Council or by the House of Delegates until such time as each component society has had ample time to review this study. On motion (Goodwin-Williams) it was voted that the study be completed and that the unit value relationship be sent to each component county medical society for study prior to the next meeting of the House of Delegates. The Fulton County Medical Society letter is to be answered to this effect.

M.D. Hospital Staff Relationship Problem

Dr. Simpson reported on a particular case. On motion (Mauldin-Simpson) it was voted to write the physician involved to take the matter up with the county medical society because MAG has no jurisdiction until action is taken by the county medical society.

AMA-ERF

Mr. Richard Nelson stated that the AMA-ERF plan to obtain funds was to contact Executives of large companies with headquarters in Georgia, to attempt to obtain contributions to AMA-ERF on this project. The state medical associations would work with AMA-ERF on this project. On motion (Mauldin-Goodwin) it was voted to cooperate with the suggested plan.

MAG Life Member Privileges

Dr. McDaniel stated that a life member had asked about a free subscription to the *JMAG* for life members. Dr. Mauldin stated that no other requests had been made by life members for the *JMAG*. No action was necessary.

State Board of Health Appointments

Dr. Mauldin reported on the First, Second and Ninth District appointments. After discussion by the Executive Committee, in the absence of recommendations from the First District, the following two names were suggested: Julian K. Quattlebaum, Sr., Savannah and J. Miller Byne, Waynesboro. The Second District nominees are: A. G. Funderburg, Moultrie and John W. McLeod, Moultrie. The Ninth District nominees are: Arthur M. Hendrix, Canton, and P. K. Dixon, Gainesville. On motion duly made and seconded it was voted to instruct the Secretary to inform the Governor of the names of the above listed.

Revision of Annual Session Program

Dr. Dillinger read the proposed revision of the Annual Session program recommended by the committee composed of Dr. Dillinger, Dr. Hydrick and Dr. Walker. On motion (McDaniel-Simpson) it was voted to approve the program revision as presented.

Public Health Physicians Association Request

Mr. Krueger stated that a request had been received from the Georgia Chapter, American Association of Public Health Physicians, to participate in the scientific program of the Annual Session. On motion (Goodwin-McDaniel) it was voted to approve this request of the Public Health Physicians Association.

Certificates of Service

Dr. Goodwin stated that a Certificate of Service had been suggested at the March Council meeting to be awarded to a member elected to an office. It was suggested that a draft of the Certificate be drawn up and sent to Dr. Goodwin to present at the next meeting of Council for approval.

Allotment of Councilors Per District

Dr. Dillinger appointed a committee as follows: Thomas W. Goodwin, Augusta, Chairman; Charles T. Cowart, LaGrange; Frank A. Wilson, Leslie; John Kirk Train, Savannah; and M. A. Hubert, Athens, to study the proposal to restrict the number of Councilors from any one district. These appointees are to be notified of their appointment and that a meeting will be held on the call of the Chairman at some future date. The recommendations of this committee are to be referred to the Constitution and Bylaws Board.

Legislative Report

Mr. Moffett asked the opinion of the Executive Committee about the possibility of Dr. Edward R. Annis, President of the AMA, addressing the Joint Session of the Georgia General Assembly during the 1964 session. On motion (McDaniel-Williams) it was voted to approve this suggestion and the Legislative Board is to initiate the plan for inviting Dr. Annis.

Testimony before the House Ways and Means Committee was reviewed and on motion it was voted that a three man committee composed of the President, Secretary, and the Chairman of the Sub-Committee on National Legislation collaborate on and have authority to approve the final writing of the Ways and Means testimony against the King-Anderson bill.

St. Paul Insurance Company Letter

Mr. Krueger explained that St. Paul Insurance Company would like to mail a letter to MAG members regarding a rate increase in premiums. After discussion, on motion (Mauldin-Simpson) it was voted that the letter suggested by St. Paul be rejected and that Dr. Jones be authorized to see a compromise letter for MAG consideration and make a report to the Executive Committee on this matter at the next meeting.

Constitution and Bylaws Revision Re First Vice President

Mr. Krueger stated that there was one other paragraph in the Constitution and Bylaws which referred to the First Vice President and would have to be changed to conform to the recent revision to allow the First Vice President to become a full voting member of the Executive Committee of Council. He asked authority to change this paragraph on the basis of the MAG Attorney's recommendation to make it correspond with the other changes made. On motion duly made and seconded it was voted to authorize the change to be made.

June 1963 AMA House of Delegates Actions Report

Mr. Krueger reported on: (1) Interns and Residents salaries being paid from fees collected by the attending physician or out of fees collected under any type of medical-surgical insurance coverage; (2) 25 per cent Rule Deleted regarding proportion of foreign medical graduates to American and Canadian medical school graduates in the approved internship programs; (3) AMA Pension Plan; (4) Composition of AMA Council on Medical Education; (5) Drug Store Ownership by a physician; (6) Dispensing of Glasses by Ophthalmologists; (7) Drug Repackaging Companies; (8) Pharmaceutical Company Stock; (9) Hill-Burton Grants for Diagnostic and Treatment Centers; (10) Mental Health Legislation; (11) Health Professions Educational Assistance Act of 1963; (12) Opposition to Construction of New V.A. Hospitals; (13) Podiatry Study; (14) Refilling Prescriptions. It was Mr. Krueger's suggestion that the above information be transmitted to the membership in the form of an Officers Newsletter to the County Medical Society Officers, and on motion this was approved.

Podiatry Association Request

Dr. Mauldin read a letter dated June 12, 1963, from the Georgia Podiatry Association asking that a meeting with the MAG and their Association be arranged to discuss relations between medicine and podiatry in Georgia. On motion duly made and seconded it was voted that the President be authorized to appoint a committee, with Dr. Fred Allman as chairman, Dr. McDaniel, as an ex-officio member, and three other members, to meet with the Podiatry Association. The Podiatry Association is to be notified of this action.

Headquarters Office Report

Mr. Krueger brought several items to the attention of the Executive Committee as follows:

(a) Georgia Association of Broadcasters: A letter from the

THE ASSOCIATION / Continued

GAB was read and referred to the Public Service Board for report at the next Council meeting.

(b) Medical Society Executives Association Membership: After discussion on motion duly made and seconded it was voted to recommend to Council that membership in the MSEA for Mr. Moffett and Mrs. Wooten be approved with membership dues to be taken from the Contingent Fund.

Old Business

(1) *Poole and Wood Retirement Plan Letter*: Dr. Mauldin stated that a letter from the Poole and Wood Insurance Agency had been mailed to individual members regarding H.R. 10 (Retirement Plan for Professional Persons). This was received for information.

(2) *A letter from Dr. G. C. Cole, Dallas, Georgia*, was read regarding his condition. On motion duly made and seconded it was voted to continue his pension payments.

(3) *Replies to letters from insurance companies regarding the Georgia Plan* were read by Dr. Mauldin. This was received for information.

(4) *Talmadge Liaison Committee*: Dr. Dillinger discussed his opinion regarding the terms of office for members of this committee and stated that he had written Dr. C. H. Richardson, Chairman of the Committee, about this with copies to Dr. Harry O'Rear, Dr. T. A. Sappington, and Dr. Preston Ellington.

New Business

(1) *U. S. Public Health Service and National Academy of Science meeting*: A letter about a meeting on institutionally-acquired staphylococcus infections to be held September 4-6, 1963, in Minneapolis, was read. By decision of the Executive Committee no representative from MAG should attend.

(2) *Diabetes Association of Atlanta Requests*: A letter from the Diabetes Association of Atlanta was read requesting office space in the MAG Headquarters Building for the annual diabetes detection drive. After discussion it was voted to write the association that no office space was available.

(3) *Georgia Hospital-Medical Council Letter*: A letter from the Georgia Hospital-Medical Council was read thanking the MAG for the contribution of \$500.00 to help defray the expenses of printing the new Standards Manual for the Georgia Hospital-Medical Council.

(4) *Pathology Letter*: After discussion regarding a problem of tissue examination in a private laboratory on hospital patients, it was voted to refer this matter to the AMA Judicial Council and to write the physician of this action.

(5) *Date and Site of August Executive Committee meeting*: August 15, 1963, 12:00 noon luncheon-meeting, at Washington, Georgia, at the time of the Tenth District Medical Society meeting.

There being no further business the meeting was adjourned at 8:10 p.m.

POSTGRADUATE COURSE IN MEDICAL ASPECTS OF SPORTS PRESENTED IN ATLANTA



Jack C. Hughston, M.D., orthopedic surgeon from Columbus and Chairman of the Medical Aspects of Sports seminar prepares to introduce a guest speaker.

"The Medical Aspects of Sports," a postgraduate course for coaches, physicians, trainers and educators was presented August 9, 1963, at the Academy of Medicine, Atlanta. The Medical Association of Georgia

sponsored the program in cooperation with the Georgia High School Association, Georgia Athletic Coaches Association, Georgia Department of Public Health, Georgia Department of Education, and the Georgia Dental Association. Jack C. Hughston, M.D. of Columbus served as Chairman, and Fred Allman, M.D., Atlanta, was Co-chairman.

The topics and their speakers were as follows:

"Physical Requirements for Participation in Athletics," Fincher Powell, M.D., Decatur; "Safety Rules in Athletics," Mr. Sam Burke, President, National Federation State High School Athletic Association, Thomas-ton; "Equipment and Injuries," Earl Lewis, M.D., Macon; "Knee and Ankle Injuries," Edmond J. McDonnell, M.D., Orthopedic Surgeon for Baltimore Colts and Orioles, Baltimore, Maryland; "Heat Exhaustion," Mr. Henry Andel, Athletic Trainer, Georgia Tech, Atlanta; "Energy Expenditure During Rest and Exercise," Walter Bloom, M.D., Atlanta; "Boils, Blisters, and Abrasions," William L. Dobbs, M.D., Atlanta; and a movie narrated by Dr. Allman entitled, "Agility Drills."

A luncheon was held in the interim between the morning and afternoon sessions and a critique was held at the termination of the entire program.

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Contents

Scientific Articles

ORAL CONTRACEPTIVES IN THE IMMEDIATE PUERPERUM Earnest M. Curtis, M.D.; Neal H. Newsom, M.D., and R. Peery Grant, B.S.	425
CONGENITAL ANOMALIES ASSOCIATED WITH CLUBFEET J. H. Kite, M.D.	429
THE ROLE OF THE PHYSICIAN IN COMMUNITY MENTAL HEALTH James W. Osberg, M.D.	432
TOPICAL TREATMENT FOR SKIN DISEASES Lamar S. Osment, M.D.	436

Editorials

EXFOLIATIVE CYTOLOGY	439
THE MERITS OF A GIFT	440
OXYGEN THERAPY	441

Features

President's Letter	443
Cancer Page	445
Heart Page	447
Mental Health Page	451
Abstracts	453

The Association

Deaths	454
Societies	455
Personals	455
MAG Sub-Committee on Mental Health Meeting, August 25	456
Advertising Index	56A
Calendar	450

Cover

Photomicrograph of malignant cells from carcinoma of the cervix, magnification X 600.
From the Departments of Pathology and Medical Illustration, Emory University School
of Medicine, Atlanta.

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ORAL CONTRACEPTIVES IN THE IMMEDIATE PUERPERUM

Earnest M. Curtis, M.D.; Neal H. Newsom, M.D.; and
R. Peery Grant, B.S., *Atlanta*

■ **No significant complications have been encountered in the authors' experience with twenty-five patients.**

THE RECURRENCE of pregnancy very soon after delivery is a problem well-known to every obstetrician. It is serious in that group of patients who are unaware of, or indifferent to, the medical, financial, and social advantages of proper family planning. Of even greater concern are those patients needing some sort of a surgical procedure such as anterior vaginal repair or sterilization, but who cannot avoid pregnancy long enough for this procedure to be carried out. Having already found that the mechanical methods of contraception are often not effective for these patients, we have undertaken a study of oral contraception beginning immediately after delivery.

Selection of Patients

To date, 58 multiparous women have been selected for this study. Most were chosen because of their need for some surgical procedure.

This preliminary report is concerned with 25 patients who were followed for at least three months. Of these, 19 received some form of oral contraceptive while the other six were not medicated but given routine mechanical contraceptive assistance.

These women ranged in age from 22-41 years with an average of 29, and their average parity was seven. (Table I).

For the purposes of this study, we chose one estrogen-progestogen combination (to be given in two dosage levels) and one purely progestational agent.

The latter was selected in an attempt to evaluate, indirectly, the effects of excessive estrogen on the involutional process.

Each patient was placed at random on either Enovid five mgm.* (Norethynodrel with Mestranol), Enovid 2.5 mgm., Norlutin ten mgm.** (Norethindrone), or no medication. Each was carefully instructed to continue the medication for 20 days and then stop. If a menstrual flow ensued, she was to resume her next cycle on the fifth day of bleeding. If no bleeding had occurred, she was to resume medication anyway on the seventh day. The medication was supplied to the patient in unmarked packages.

Of the 25 patients included in the present report, four received their initial medication on the day of delivery, 12 on the following day, eight on the second day, and one started her treatment on the third day afterward.

These patients were discharged as usual on the second or third day after delivery, and were instructed to return at one month intervals to the Outpatient Department for examination and a refill of their prescription.

TABLE I
SELECTION OF PATIENTS

	Number	Average Age	Average Parity	Number Operated
Enovid 5 mgm	9	27	7	6
Enovid 2.5 mgm	6	29	8	3
Norlutin 10 mgm	4	28	7	1
Control	6	30	7	6
TOTAL	25	29	7	16

From the Department of Gynecology and Obstetrics, Emory University School of Medicine, Atlanta, Georgia.

Note: The medications used in this project were supplied by the manufacturers, and additional financial support was given by G. D. Searle & Co.

*G. D. Searle & Co.
**Parke, Davis & Co.

TABLE II
BREAST FEEDING

	Total	Desiring	Success 1 mo.	Success 2 mo.	Success 3 mo.	Per cent "success"
Enovid 5.0	9	3	1	1	1	33%
Enovid 2.5	6	4	3	2	2	50%
Norlutin 10.0	4	1	0	0	0	0%
Control	6	6	3	2	2	33%

At the subsequent visits, each patient was carefully questioned and examined, in nearly every instance, by the authors.

Those patients for surgery (16 out of 25) were admitted as soon after the third examination as was possible. The delay between delivery and surgery averaged 14 weeks.

Of the observations made throughout the postpartum period, the following seem most important.

Pregnancy

No pregnancies occurred in either the medicated or the non-medicated patients included in this report. It is felt that the small number of patients make it impossible to draw any conclusions, but the efficacy of oral contraceptives is well-documented elsewhere.¹

Of the 25 patients followed here, 14 were desirous of breast feeding. The remainder either were not interested or had delivered stillborn infants. By chance, a smaller proportion of medicated patients chose to breast feed. (Table II).

Taken as a single group, the medicated patients were able to feed successfully for one month in about 50 per cent of the cases. This fell to 38 per cent by the end of the third month. Among those receiving no medication, the success rate at the end of the third month was almost exactly the same.

Less Milk

It is interesting to note, however, that when questioned, nine of the 19 medicated patients felt that they had had less milk than in previous pregnancies. An equal number felt they had had the same amount and one actually felt she had more. Nearly all of the untreated patients felt they had the same amount as before. These differences were not confirmed in the overall "success" rate since, as stated before, this was nearly identical in both groups.

TABLE III
LOCHIA RUBRA

	Enovid 5.0	Enovid 2.5	Norlutin 10 mgm.	Control
Duration (weeks)	4	2.5	2	4

The continuation of lochia rubra, while not necessarily of great significance, is of some interest. This is one of the least objective of the determinations, and was obtained by history from the patient herself, and on some occasions confirmed at the time of examination. (Table III). It is interesting to note that those patients receiving Norlutin averaged the least amount of lochia rubra (14 days) while those on Enovid five mgm. reported the longest duration (27 days). Among those patients who had not received any medication, the duration of the reddish discharge averaged 28 days which is longer than is usually considered normal.

Number

The number in each of these groups is probably too small to draw any definite conclusions, and it should be mentioned that in an additional group of 20 patients followed for a shorter period of time, there was no significant difference in the duration of lochia among any of the groups.

The average interval between delivery and the time of menstrual flow in the entire 25 patients included in this study was about eight weeks. This was difficult to determine because a few patients had

TABLE IV
RETURN OF MENSTRUATION
(Weeks Postpartum)

	Enovid 5.0	Enovid 2.5	Norlutin 10 mgm.	Control
Entire Series	7	6	9+	8+
Non-breast- feeders	7	6	9+	5

not yet resumed menses by the end of the third postpartum month. (Table IV).

Since it is well-known that breast feeding usually delays the return of menstruation, those patients nursing for less than one month were considered separately. The only significant difference was in the group which had received no oral contraceptives. Here the menses returned in an average of five weeks.

Contrary to what one might expect following the early return of cyclic estrogen stimulation of the endometrium, these results suggest that the menses may actually be delayed.

It should be noted that menstruation in all these patients returned within the limits mentioned by Eastman² and that in several patients it did so prior to cessation of breast feeding.

Involution of the Uterus

The involution of the uterus is, of course, of particular interest in preparation for vaginal surgery after delivery. Pelvic examination was performed on each patient at monthly intervals. At these times,

TABLE V
UTERINE MEASUREMENTS
Bimanual Examination

	1 Month	2 Month	3 Month
Medicated (Average cm.)	8x6x5	7x5x4	7x4x4
Control	6x4x4	6x5x4	6x4x3

each observer attempted to outline the uterus as accurately as possible and set down his estimate of the length, width, and thickness, all without prior knowledge of the particular patient's regime. (Table V).

As one would expect, there was a gradual reduction in the size of the uterus from the first to the third visits. Judging from the average of all the measurements taken in the various groups, it seems that the uteri of women who had not received any oral contraceptive were about one cm. less in each diameter than those patients who had been treated. This difference was even less pronounced by the third post-partum examination. (Table VI). These figures suggest that there may be some slowing of uterine involution in medicated patients.

Complications

During each post-partum interview, the patients were asked first to volunteer any unpleasant signs or symptoms of medication and then were asked about specific problems.

Of the 19 patients who had received some sort of medication, only three complained of nausea and in none of these was this severe enough to stop the medication. Several study patients, not included in this report, did drop out because of bothersome nausea. It was interesting to note that the symptom of nausea was also noted in about the same percentage of non-treated patients.

Weight gain and headaches are symptoms difficult to evaluate, and they occurred in several of the patients with and without medication.

One particularly interesting side effect was found in a patient receiving Enovid five mgm. She was one of the patients who successfully breast fed while on a cyclic contraceptive. Just prior to her examination at five weeks, she had begun to notice considerable increase in the size of her male newborn infant's breasts. Examination thereof revealed soft tissue enlargement several times normal in both breasts. (Figure 1). No other cause for gynecomastia could



Figure 1

be found. Breast feeding was discontinued and the size of the baby's breasts returned to normal. This suggested the transmission of estrogen-progesterone effects through breast milk to the fetus and represents the first case of "feminization" of the male infant that we have seen.

Of the 25 patients included in this study, 16 underwent either vaginal hysterectomy or tubal ligation. The observations mentioned here are those of the authors made at the time of surgery and of the surgeons involved.

There did seem to be a mild increase in the vascular congestion of the vaginal mucosa in those patients who had received oral contraceptives. This did not, however, apparently result in any significant increase in operative blood loss.

In no instance was it felt that the surgery was made significantly more difficult by the previous medication, and in some of the cases the tissue planes seemed to develop more easily than usual.

There was no increase in the postoperative complications in any of the groups in this study.

Uterine Size

The average weight of the uteri removed from patients having received Enovid five mgm. is 151 Gms. The average weight of those removed from patients receiving 2.5 mgm. was 141 Gms. These differences are probably not significant, but both these weights are greater than the normal limit, 60

TABLE VI
UTERINE SIZE
3 Months Postpartum
(in cm)

	Enovid 5.0	Enovid 2.5	Norlutin 10	Control
Bimanual Exam	7x4x3	7x4x4	7x5x4	6x4x3

TABLE VII
PITUITARY GONADOTROPINS

Patient	Medication	Level
1	Control	High
2	Control	High
3	Enovid 5.0	Low
4	Enovid 5.0	Low
5	Enovid 2.5	Low

Gms. given by Greenhill.³ The length and width of those uteri removed from patients receiving the larger dosage of Enovid was about 0.5 cm. greater than those patients receiving the smaller dosage, and both of these are slightly larger than the control group.

This tends to confirm the surgical impression and that of the preoperative examination, that those patients receiving oral contraceptive failed to reduce the size of their uteri quite as much as the control group.

Pathologic Findings

Although these studies are incomplete, we believe that the endometrial findings already described by others will be present.⁴ No myometrial abnormalities have been recognized.

Organized intravenous thrombi have been found in at least one patient receiving oral contraceptive, but this is probably a normal process of uterine involution.

A more complete report of our findings will be published at a later time.

Pituitary Gonadotropin Studies

We were able to obtain accurate assays of follicle stimulating hormones through the facilities of Dr. Albert F. Parlow on six of the patients in this study. Two of these had received Enovid five mgm., one had received Enovid 2.5 mgm., and the other two were control patients. The results of these studies are found in Table VII.

In both the control patients the pituitary gonadotropin level was higher than usual for the normal, non-pregnant adult females. Of particular interest

were the lower-than-normal values for all patients on Enovid.

This is a preliminary report based upon observation of 25 multiparous women, of whom, 19 were given either an estrogen-progestogen compound or a progestational agent in a cyclic fashion for 20 days out of each month, beginning soon after delivery. An additional six patients served as controls.

Based upon the observations of these patients, we feel that we can make the following tentative conclusions:

1) Oral contraceptives are probably just as effective in the puerperum as they are at any other time in the prevention of pregnancy.

2) No added maternal hazards in the puerperal use of oral contraceptives have been found.

3) There is a general reduction in the quantity of breast milk among treated patients as observed by the patients themselves. In spite of this, there is essentially no difference in the success rate of breast feeding between the control group and those on medication.

4) Breast feeding may continue even after menstrual flow has returned.

5) Estrogen effects upon breast feeding infants are possible.

6) There is both subjective and objective evidence that the uterine size is slightly greater in patients receiving oral contraceptives in the puerperum.

7) Incomplete studies suggest that the levels of pituitary gonadotropins are lower in patients receiving medication.

8) In spite of an apparent increase in pelvic vascularity, no significant additional technical difficulties are encountered at surgery, and no increase in postoperative morbidity is to be expected.

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AMERICAN THORACIC SOCIETY ANNOUNCES RESEARCH GRANTS

Applications for research grants awarded by the American Thoracic Society, medical section of the National Tuberculosis Association, will be received between now and December 15, 1963. Grants will be awarded for medical and social research in the field of respiratory diseases, including tuberculosis, for the year

beginning July 1, 1964. For further information and forms, communicate with:

Division of Research & Statistics
American Thoracic Society
1790 Broadway
New York 19, New York

CONGENITAL ANOMALIES ASSOCIATED WITH CLUBFEET

J. H. Kite, M.D., *Atlanta*

- ***The author's experience with 1,509 clubfoot cases forms the background for this report.***

IN DISCUSSING the congenital malformations associated with clubfeet, it is desirable first to survey the entire field of congenital deformities. Davis and Potter¹ state that malformations occur more commonly in males than females and in white than non-white, and in children of women who are near the beginning or end of the age when reproduction is possible. U. S. Children's Bureau in 1940, discussing the contribution of congenital anomalies to total cases of disability, show that congenital anomalies make up 20.7 per cent of the disabilities, while polio makes up 18.9 per cent. Clubfoot alone caused 7.4 per cent of the disabilities.

Statistics

Ivy² reviewed all of the congenital anomalies as noted on the birth certificates in Pennsylvania from 1947 to 1956. Congenital anomalies were recorded in about 8.5 per 1000 of total births. Of these, about 60 per cent occurred in males and 40 per cent in females. Each year the list is headed by clubfoot, followed closely by cleft lip and cleft palate. Other anomalies most frequently recorded are spina bifida, polydactylism of fingers, hypospadias, congenital heart disease, mongolism, birthmarks, anencephalus and hydrocephalus. In about 6.4 per cent multiple anomalies are recorded. In the five year period from 1951 to 1955 there were recorded 1810 clubfeet, 1269 cleft lip and cleft palate, 715 spina bifida, and 703 polydactylism of fingers.

Ivy³ in 1962 reported on the influence of race on the incidence of certain congenital anomalies. Clubfoot led the list with 300 white and 19 Negro. Cleft lip and cleft palate 284 white and six Negro. Polydactylism 54 white and 102 Negro.

Sesgin and Stark⁴ also found that foot deformities are the most common of congenital anomalies, and their figures showed equinovarus to be 30, metatarsus adductus 55 and hare lip and cleft palate 21.

Types of Malformation

McIntosh et al⁵, from the Sloane Hospital for Women, reporting on 5,964 pregnancies found congenital deformities in 7.5 per cent. White 6.3 per cent. Non-white 7.8 per cent. In infants weighing less than 2,500 grams, 9.7 per cent. Over 2,500 grams, 6.7 per cent. Maternal age had no effect on the incidence of congenital malformations. Malformations of the musculo-skeletal system and skin were more frequent than malformation of other systems. Of the malformed infants, 14.8 per cent had more than one malformation, and in 9.1 per cent more than one system was involved. They found 53 metatarsus varus cases, 25 clubfeet, 30 polydactylia, eleven with syndactylism, and spina bifida in six cases.

I have made a careful tabulation of 1,509 clubfoot cases treated by me between 1924 and 1960 at the Scottish Rite Hospital for Crippled Children and at my office. I am reporting at this time only one phase of this study, and this is the congenital anomalies associated with clubfoot.

Presented at the 109th Annual Session of the Medical Association of Georgia, May 5, 1963, Jekyll Island, Georgia.

CLUBFEET / Kite

When a child presents one congenital anomaly, there is a greater chance than normal of finding another deformity in the same child. When orthopedists are asked what is the most common deformity associated with clubfoot, a variety of answers are given. In order to be more accurate, only the common variety of clubfoot was counted. In this series there were 59 cases (four per cent) of arthrogryposis multiplex congenita with clubfeet, which were eliminated, and also three achondroplastic dwarfs. The 1,447 remaining typical clubfoot cases presented 283 associated deformities. The actual number of cases affected were a little less because some cases showed more than one additional deformity.

Metatarsal Varus

The most frequent congenital abnormality was a metatarsal varus deformity in the other foot. Of course, this occurred in the cases with unilateral clubfoot involvement, of which there were 764 cases, or almost exactly half of the total number of clubfoot cases. Congenital metatarsus varus occurred in sixty children, or in four per cent of the entire series, or in eight per cent of the unilateral cases. The occurrence of metatarsus varus was a very rare finding in the early years of this study, but has become increasingly frequent during the latter years. This finding in clubfeet agrees with the gradual increase of metatarsus varus in non-clubfoot children during the last twenty years. During this time I have treated over 1,400 metatarsus varus patients whose deformity has not been associated with clubfeet.

Etiological Significance

This association of metatarsus varus with clubfeet may be of some etiological significance. When we know the factors which are responsible for the production of a clubfoot, we might find that some of these factors are also responsible for the production of metatarsus varus. Years ago, in order to give the parents an English name for "congenital metatarsus varus," I referred to it as a "third-of-a-clubfoot." This term has been criticized as not being entirely accurate, but we might find eventually that it is more than just a descriptive term.

The next most common deformity associated with clubfoot, is congenital deformity of the hands. The factors which might cause deformities of the lower extremity, might also cause deformities in the upper extremity. All of these limb deformities probably occur during the fifth to the eighth week while the limb bud is forming. Congenital malformations of the hands occurred in 37 cases or 2.5 per cent of the

clubfooted children. These deformities include syndactylia, ectrodactylia, polydactylia, brachydactylia and other less common deformities.

Third Most Frequent

The third most frequent deformity was spina bifida. There were 35 children or 2.4 per cent of the cases with spina bifida. However, only a small percentage of spina bifida cases are clubfooted. In over 30,000 children with orthopedic conditions treated at the hospital and office, there were 249 cases of spina bifida. Two hundred seventeen of these cases were spina bifida vera with a tumor on the back, and 30 were spina bifida occulta, where the diagnosis was made by X-ray. Thirty-five or 16 per cent of these 249 cases had clubfoot deformities. In most of the cases the neuro-surgeons removed the tumor mass on the back, which greatly facilitated the treatment of the clubfeet. In an occasional case, the tumor was so large the surgeons decided not to remove it. There were three clubfooted cases with spina bifida occulta. In most of the clubfooted cases the deformity of the feet was typical of the common clubfeet. In a few the deformity was atypical. In some the feet were more relaxed. If there was gross nerve involvement the correction did not take as long. If there was a gross muscle imbalance, the deformity was more prone to recur. Care must be taken in the spina bifida cases not to over correct the foot into a flat foot deformity.

The Hip

The fourth deformity in frequency was congenital dislocation of the hip. Sixteen children or roughly one per cent had one or both hips dislocated. All of these hips were successfully reduced by closed reduction. As far as we could tell, these hips did not offer any more difficulties in reduction than the ordinary dislocation of the hip. In some cases we treated the clubfeet first, and when these were about ready to be held, we reduced the hips, and held the hips and the feet in the corrected position at the same time. One dislocated hip reduced itself spontaneously while the patient was wearing casts extending to the midthighs. The legs rolled out and were for the most part kept in abduction. No further treatment was required for this hip.

Twenty patients had an absence of some part of the leg. Eleven had absence of the toes, three of the tibia, two of the fibula, and one each of the patella, talus and cuboid.

Severe flat foot deformity occurred in the opposite foot in 12 of the unilateral cases. In these, the deformity was severe enough to require treatment by casts to correct the flat foot deformity.

Thirteen were mentally deficient. Ten had in-

guinal hernias. Seven had a cleft palate and two a cleft lip. Seven were mongolians. Six had a congenital groove in the leg or arms and six presented polydactylia of toes or fingers. A rather large hemangioma occurred in five. Four had deformities of the knees, and four adduction of the thumb severe enough to require treatment. Congenital contracture of the elbow was present in three. Three had congenital heart defects which were treated elsewhere. Three showed marked tibia bowing.

Two each had the following: Dwarfism—proportionate, osteogenesis imperfecta, progressive muscular dystrophy, pyloric stenosis, rachischisis, short legs and spondylothesis.

One each had the following: Absence of the sacrum and lumbar spine, arachnocytylia, calcaneus doubled, chondroectrodermal dysplasia, cretinism, deafness, eye deformity, femur deformity, fusion of talus and navicular, hemivertebra, hydrocephalus, lobster claw hand, mortised toe epiphysis, patella dislocation, ribs deformed, short arm, tibio-fibula synostosis, tibia kyphosis and trigger thumb.

A tabulation has been made of the congenital anomalies occurring in 1,447 typical clubfoot cases. The most common abnormality was a congenital

metatarsus varus deformity in the other foot. This occurred in 60 children with unilateral clubfoot deformity, which was four per cent of the entire group, or eight per cent of the unilateral cases. Deformity of the hands occurred in 37 patients or 2.5 per cent. Spina bifida occurred in 35 or 2.4 per cent. Congenital dislocation of the hip was found in sixteen or one per cent. Absence of a part of the foot in 20, flat foot needing treatment in the other foot of the unilateral cases in 12. About 50 different anomalies occurred in the 283 cases. Twenty per cent of all of the clubfooted cases showed an associated deformity.

490 Peachtree Street, N.E.

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7,000 REGISTRATIONS EXPECTED AT AMA PORTLAND MEETING

More than 7,000 physicians and their guests are expected to converge on Portland, Oregon, for the 17th Clinical Meeting of the American Medical Association, December 1-4.

It will mark the first time that the AMA has held a clinical meeting in Portland. The association has held two of its annual meetings in Portland, however, in July, 1905, and in July, 1929.

Memorial Coliseum

Dr. Otto C. Page, general chairman of arrangements for the December meeting, said nearly all of the scientific sessions will be held in Portland's new Memorial Coliseum. The scientific and industrial exhibits also will be shown there. Conveniently located within a few miles of the business district, the multi-million dollar Coliseum offers new facilities throughout.

When the AMA held its clinical meeting in Seattle in 1956 the total physician attendance was 3,032.

"We feel," Dr. Page said, "that this figure will be much higher when the AMA meets in Portland."

The secretary-treasurer of the AMA Board of Trustees, Dr. Raymond M. McKeown, lives in Coos

Bay, Oregon, and he, too, expects an exceptionally high attendance.

"The majority of doctors," he said, "will come from the Pacific Northwest, but there should be good representation from other states along the West Coast and also from the Mountain states."

Lectures, panels, symposia and breakfast roundtables again will be presented at the Portland meeting on specially selected topics, as well as color television and medical motion pictures. More than 100 physicians will deliver lectures on the scientific program during the four-day meeting, and more than 200 scientific and industrial exhibits will be shown at the Coliseum, many of which will be based on new scientific research.

Exhibits

Dr. Huldrick Kammer, chairman of the Scientific Program Committee, said the scientific exhibits are an important part of the clinical meeting and added that "their long and continued popularity at AMA meetings is good evidence of their teaching value to the physician. The exhibits are so varied that the medical subject matter has some interest to every physician regardless of specialty."

THE ROLE OF THE PHYSICIAN IN COMMUNITY MENTAL HEALTH

James W. Osberg, M.D., *Silver Spring, Maryland*

- *The family physician may be viewed as the "gatekeeper" between the general public and psychiatry.*

DURING THE PAST several years there have been a number of most significant developments in American psychiatry and in American medicine which provide background in considering the role of the physician in mental health in the community. These developments are from several aspects dramatic, exciting and have the characteristics of fundamental social change. Among the developments may be cited the discovery and the widespread use of the tranquilizing and the anti-depressant drugs which make it possible to rehabilitate many patients in our large state hospitals and provide a method of treatment for many patients in the community.

Instituted Approaches

But probably more significant than the pharmacological and psychological effects of the drugs, is the fact that the drugs have made it possible for other treatment approaches to be instituted, most notably the opening-up of hospitals, and the humane treatment of patients. At the present time there are more patients admitted with psychiatric or emotional problems to general hospitals in this country than to the large mental hospitals. The widespread use of these drugs in the general hospital has permitted treatment of the patient in the community close to the family without severe disruption of living patterns. Psy-

chiatric services in general hospitals have increased remarkably. Twenty years ago only 48 general hospitals admitted mental patients as compared to over 600 in 1960. Almost 200,000 mental patients were admitted in 1960, 30 per cent more than in 1953. Perhaps of even greater significance than these developments has been the trend to move the management and treatment of the mentally ill and the emotionally disturbed into the community with a steady growth of such facilities as the day hospital, halfway houses, clinics, and the increasing role of professional persons within the community.

Examples in Georgia

In Georgia there are two outstanding examples of this: the utilization of the public health nurse in an extensive followup of patients discharged from the mental hospital and the development of the intensive treatment programs in four major centers. In its aftercare program Georgia has recently extended followup care through the public health nurse to all but seven of its 159 counties and the intensive treatment program operating in four general hospitals in the state pays for intensive psychiatric treatment for indigent patients for an average of 28 days and the patient is entitled to six months followup care at a clinic. The fact that of 650 patients treated last year only eight per cent have gone on to state hospitals is an indication of the success of this program.

Presented at the 109th Annual Session of the Medical Association of Georgia, May 6, 1963, Jekyll Island, Georgia.

Equally outstanding, are the exemplary efforts to provide intensive treatment and trained staff at Milledgeville State Hospital and the administrative division of the hospital into several smaller units which will permit intensive treatment.

Medical Insurance Plans

One would note also in such a brief historical survey the increasing use of medical insurance plans for providing support of both hospitalization and outpatient treatment of the mentally ill. In many states insurance plans have become much more liberal with expanded coverage. It should be noted, however, that of the 83 Blue Cross plans in effect in the United States and Canada, only 13 offer coverage to the mentally ill that equals coverage for the physically ill. A recent study in New York in a non-profit insurance organization experimented with the feasibility of offering limited benefits to a sampling of 76,000 subscribers and dependents. The program allowed 30 days of hospital care and a maximum of fifteen office visits for which the patient pays \$5.00 and the insurance plan pays \$15.00. It is striking that there was less use of the service anticipated with only one per cent of the eligible subscribers requesting psychiatric treatment.

These changes in the American scene of psychiatry and medicine seem to reinforce a deep conviction and tradition in our culture—the conviction that wherever and whenever possible services should be provided through individual initiative and at the local level of the community. As many of you are aware, the American Medical Association with the American Psychiatric Association and with a number of other key organizations, has taken leadership to investigate problems in the field of mental health in this country and to make specific recommendations.

Emphasis

These findings published in several books by the Joint Commission of Mental Health and Illness have emphasized the goals of providing treatment in the community, the great need for increased professional manpower, and the key role of the medical practitioner. Following publication of these recommendations, the American Medical Association at its National Congress on Mental Illness and Health has endorsed the recommendations. Through the Council on Mental Health, the American Medical Association has urged the participation of physicians at psychiatric clinics, day care centers, and psychiatric units in general hospitals, has emphasized the potentiality the physician has for detecting early maladjustment and developmental problems during childhood and adolescence, and has encouraged physicians to become health advisors and leaders in com-

munity efforts concerned with problems related to potential juvenile delinquency. It is also pointed out that the medical profession recognizes the influence of the family in problems involving mental health and mental illness, that the physician has close contact with family members and that the physician should consider the family environment and its possible effect on the patient.

In addition to these developments the recent Governors' Conference gave unanimous support to these principles and at the present time bills are being introduced in the national Congress to support particularly the development of community facilities at the local level which will in President Kennedy's statement "return mental health care to the main stream of American medicine."

Opinions and Attitudes

Most pertinent to the realistic development of these programs are existing public opinions and attitudes about mental illness. A number of surveys and studies have been conducted in this area during the past few years. A team of research investigators at the Institute of Communication Research at the University of Illinois conducted a series of studies over a six year period (1954-1959). These individuals measured opinions and attitudes of the public and of specialists in the mental health field. They discovered that the public did not have clearcut opinions, that their sample did not have logically grouped patterns of opinion and appeared willing to change opinions about the mentally ill. The public, however, regarded the mentally ill with fear, distrust and dislike. The sample had moderately high positive attitudes toward mental health professionals although they valued professional workers who treat physical disabilities more than those who treat mental disabilities. In addition the researchers found that the general practitioner had a good opinion about psychiatry, physicians stating that 54 per cent of the cases referred to a psychiatrist were helped considerably with only 30 per cent receiving little or no help. They recognized the role of mental problems in their patients' complaints, 77 per cent reporting that they treated some kind of mental illness themselves.

The Need for Help

In another study related to the final report of the Joint Commission on Mental Illness and Health, a survey conducted indicated that one out of every four Americans has felt the need for help with emotional problems and one in every seven has sought that help. Of those who had sought help 42 per cent had consulted clergymen, 29 per cent physicians, eighteen per cent psychiatrists and psychologists, and

ten per cent agencies or marriage clinics. Strikingly, 65 per cent of these who consulted clergymen or physicians believed that they had been helped whereas only 46 per cent of those who consulted psychiatrists said so. It should be mentioned that psychiatrists see the more difficult cases.

The Individual

One other major development in American psychiatry should be emphasized—historically, psychiatry in America had its roots in the basic attempt to understand the psychological functioning of the *individual* with an exhaustive and primary concern about the individual's psychological function. Although environmental factors, including the effect of relationships with others, the effect of family members, friends, the capacity to function on the job, the influence of the school, the church and the wider culture have been considered, only recently has there been a significant increase of interest, concern, and investigation of these factors. There has been, for example, increasing interest in trying to understand the function of the child in the family, to provide for specific remedial efforts directed toward the family as a whole or toward the child within the school system. In our own experience when we have seen total families, in treatment, we have found that it does appear possible to effect rather rapid changes in adjustment on a relatively short-term basis, particularly during a crisis situation and where there is an adolescent experiencing an emotional problem. It would appear that the attempts of mental health professionals to move in these directions brings them much closer to the experience and the concerns of the physician dealing with the family.

Specifics

With this brief sketch, what might we say more specifically about the role of the general practitioner, the internist and of the specialists in relation to mental health problems which arise within the community? We have noted that the public views the general practitioner as the first person to contact for advice and information about mental health problems, that general practitioners state a sizable percentage of their patients are troubled by mental problems, that really all general practitioners are aware of psychiatric referral sources, that many referrals are made and that many mental cases are not referred but are treated by general practitioners themselves. General practitioners may be viewed as the "gatekeepers" between the general public and psychiatry. Particularly in rural and semi-rural areas the physician has intimate knowledge of his community

and also has much intimate and thorough knowledge of the family. Because of this familiarity with the patient, the family and the community, the family physician is particularly valuable for psychiatric case finding; he is more likely to see the patient while a mental illness is developing. Because of his training in other aspects of medicine, he potentially can prescribe many of the newer and more effective psychiatric therapies which depend on the tranquilizers and anti-depressants. Because of his acceptance by the patient and the family, and because of his prestige, the physician is not only heard when he speaks but his listening to a patient may be one of the most effective tools in his armamentarium.

As has recently been pointed out by Dr. Robert H. Felix, Director of the National Institute of Mental Health, non-psychiatric physicians frequently forget a basic medical fact, that whether they designate it so or not, every physician makes use of psychotherapy. No physician can come in contact with a patient without having a personal influence on him for better or for worse. A goal would be to treat the person as a whole, his physical self, psychological, and emotional self—his social self.

Referral or Consultation

I would like to mention some of the situations in which it might be helpful for you to refer a patient to a psychiatrist or to consult with one. If after a careful physical and psychological evaluation there appears to be no evidence of physical disability but reason to suspect psychiatric problems, a referral or consultation would be in order. Complaints of severe headaches, profound sleep loss, tachycardia, dyspnea, back pain without demonstrable organic pathology would be an indication for referral and consultation as well as in situations where there is marked overlay of emotional problems on organic components of a physical illness. Thirdly, when the emotional components of an illness are obscured or when crisis situations present, such as suicidal tendencies in a patient, assistance should be sought. I would like to quote from Dr. Hyman of Tennessee on when not to refer a patient to a psychiatrist:

- (1) Don't refer a patient to a psychiatrist if you need to use high pressure tactics to get him there.
- (2) Don't refer to a psychiatrist if you have to promise quick results.
- (3) Don't refer the patient to a psychiatrist for reassurance that you yourself are equipped to give.
- (4) Don't refer a patient to a psychiatrist for treatment of a personality problem unless the patients wants it treated, and don't treat it yourself.

We have been talking specifically about the role of the physician with the patient. I would like to comment briefly on the innumerable opportunities that the physician has available as a leader in the community to be a primary "community agent."

Varying Opportunities

These opportunities may vary from the physician's support of meaningful mental health developments in the school system, through his lending his knowledge and support in attempts to solve problems of delinquency and alcoholism, to the innumerable opportunities any physician has to influence the attitude of the public in accepting the responsibility of treatment, and correcting the many attitudes which impede the development of the child in the home and in the community. We talk much about the treatment of mental illness, case finding, but we know and say little about prevention. One of the greatest challenges to the physician and to other key figures in the community is related to an attempt to recognize and to ameliorate those circumstances in the community and in our culture which we suspect play a large part in the development of maladjustments. I hesitate to speculate what these conditions are in any detail but they certainly would appear to be related to such factors as the respect of one individual for another, the recognition of individual differences among people, the recognition of the possibility of growth toward maturity at any age, and the recognition of the catalyzing effect of emotional and human support.

Finally, some thoughts about a most precious commodity—time. None of us seems to have adequate time to offer our patients but even in a brief con-

tact it may be possible to convey to the patient an attitude of confidence and understanding. As we work increasingly closer as physicians, we may well be able to develop brief interview techniques. In the meanwhile, we should aim for viewing the patient as a whole, searching for sounder scientific bases for our professional work, and broadening the influence and effect of the physician as a leader in community mental health efforts.

*National Institute of Health
Public Health Service
United States Department
of Health, Education and Welfare*

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**JOHN KISER APPOINTED EXECUTIVE
OF FULTON COUNTY MEDICAL SOCIETY**



John F. Kiser

John F. Kiser, a native of Atlanta, has recently been appointed as the first professional Executive Secretary of Fulton County Medical Society. Mr. Kiser returns to Atlanta from Chicago, Illinois, where he has served for two years as the New York and New England Field Representative for the American

Medical Association. Assuming his new duties September 1, he will serve as executive officer for the Fulton County organization, which now has more than 1,000

members, and will administer the society's public service, and educational and scientific activities.

Affiliated with MAG

Formerly an Associate Executive Secretary with the Medical Association of Georgia, Mr. Kiser began his career with the Association as Managing Editor of the Journal, and in the ensuing eight years, became an Associate Executive Secretary. In addition to these duties he staffed MAG committees on Legislation, History and Vital Statistics, Mental Health, Professional Conduct, Public Safety, and School Child Health.

Mr. and Mrs. Kiser and their six children are living at 6 West Andrews Drive, N.W., Atlanta.

TOPICAL TREATMENT FOR SKIN DISEASES

Lamar S. Osment, M.D., *Birmingham, Alabama*

- ***A brief review of the dermatologic situations in which local treatment appears to be the most effective approach.***

LOCAL TREATMENT is still a most potent modality in the management of most cutaneous diseases in spite of the availability of new powerful internal drugs. Its approach is direct and often rapid.

Topical agents for the treatment of skin diseases are numerous and varied. Many active pharmaceuticals are available in a wide variety of strengths, vehicles, and package sizes. For the treatment of any given dermatosis there is a great range of possible remedies.

The selection and application of the proper external remedy is a delicate task and lends itself to much trial and error. In each individual case, the choice of both the vehicle and the specific remedy depends on the appearance and course of the dermatosis. Nevertheless, certain general rules about the management of the average case may be stated.

Vehicles and Bases

Solid preparations are the most widely used. *Ointments* or *salves* are constituted mostly of animal, vegetable, and mineral fats. Ointments are greasy to feel and are useful in helping dry or senile skin hold moisture. Ointments are first choice in dry chronic, scaly eruptions, such as chronic neurodermatitis. They soften and remove adherent scales and are also somewhat macerating. This property is sometimes of help in permitting a specific active ingredient to be absorbed more readily.

Ointments tend to be unsightly and messy and are not useful in weeping areas or on infected lesions where drainage is needed. One of the types of preparations which can be used in such an event is the *cream*. Creams are solid emulsions and will absorb water readily. They are neater but in general are not very lubricating. In delivering active medicaments to the skin they are probably no more effective than ointments. *Pastes* are ointments with additional dry ingredients added. They are used less today than twenty years ago.

Liquids

Liquid preparations are more useful in widespread eruptions because they are easy to apply with the hand or a soft brush. Passage of secretions and exudations is also facilitated. Ordinary *shake lotions* like calamine lotion are made of powders with a water base. These are frequently too drying and are especially uncomfortable if secretions are profuse.

Liniments and *emulsions* are also called "lotions" and represent a compromise between shake lotions and ointments. They contain oily substances suspended in a liquid vehicle or a shake lotion. Comfort is greater since they are not too drying and also will permit flow of secretions in such eruptions as hand eczema. An excellent liniment can be made with equal parts of calamine lotion and Nivea skin oil®.

In recent years manufacturers have also used *aerosol sprays* and *foam aerosols* to package their specific active topical agents. Aerosol sprays contain under pressure the active medication with a refrigerant propellant. The nozzle should be held about eight

From the Department of Dermatology, Medical College of Alabama, Birmingham, Alabama.

Presented at the 109th Annual Session of the Medical Association of Georgia, May 7, 1963, Jekyll Island, Georgia.

inches from the area to be treated. This form of therapy is useful for moist lesions but is rather wasteful and sometimes even irritating to the skin. Foam aerosols are creamy emulsions packaged under pressure and are used in exactly the same circumstances that creams would be used and are interchangeable. Used properly and not wasted they can be economically employed to treat localized weeping areas. The medication is best propelled to the applying finger for transfer to the eruption.

Dressings and Compresses

Wet dressings or compresses are the most effective way of cleansing the skin of adherent crusts and exudates; for example, poison ivy dermatitis. Warm wet dressings are used to maintain drainage of furuncles and carbuncles. Compresses also are soothing. They should not be relied on for any strong antimicrobial effect. Solutions most often used for compresses include plain tap water, Burow's solution (one Domeboro® powder per one quart tap water), magnesium sulfate (one tablespoon to one quart water), boric acid (one teaspoon to a pint of water), and Prophyllin powders® (one package to a pint of water). Compresses are used closed or open and continuously or intermittently. Continuous compresses are used for severely involved areas. Hands and feet are best compressed only intermittently since they easily become too macerated. Open compresses become dry more rapidly than those covered with impermeable coverings such as plastic film. Any compress should be removed and rewet in a basin to keep the solution from becoming concentrated and perhaps toxic or irritating. Fabrics should be thick to prevent rapid drying. Turkish towels are excellent. Most gauze squares are too coarse. Concentrated urea solution or dilute sodium hypochlorite (Chlorpactin®, Chlorox®) are sometimes used for debridement of very tenacious crusts and necrotic tissue.

Bathing Instructions

Almost all patients with dermatoses need some special instructions about bathing. Certainly those with acne, seborrhea capitis, and psoriasis of the scalp need frequent soap and water cleansing of the involved areas. However, most patients with inflammatory skin lesions should refrain from bathing the affected parts with soap and water or even plain water.

Starch baths are widely used. Linit starch® or powdered corn starch is added (one cupful) to a tub of lukewarm water. This may be drying in the winter and often one tablespoonful of an oil (Nivea skin oil®, Lubath®, Alpha Keri®) is substituted. Special baths are usually soothing but their main pur-

pose is to keep the patient from using soap. *Superfatted soaps* (Basis®, Oilatum®) and Phisohex® are too drying for most inflammatory eruptions. It is not necessary to vigorously scrub away crusts in impetigo. This can be done gently, if at all, in this era of systemic antibiotic therapy.

Powders

Powders are absorbent and are therefore most helpful in moist intertriginous areas such as the toe webs and groin. They also serve as a sort of lubricant between adjacent skin surfaces. Prickly heat can be treated with drying powders.

Plasters are very macerating and when salicylic acid is incorporated (Duke's 40 per cent salicylic acid plaster®) an excellent keratolytic for warts, corns, or callouses is obtained.

Recent embellishments in topical treatment include "surface depot" therapy, in which an ointment or cream is applied to the skin and covered with an impermeable film such as Saran Wrap®. This has the effect of breaking down the absorption barrier of the skin and allowing larger amounts of the active principle to be absorbed. The effectiveness of corticosteroid and weak tar preparations is especially enhanced. This technique has been used extensively for neurodermatitis and psoriasis. Ingredients with any irritant quality such as salicylic acid should not be covered in this manner.

Specific Medicaments

Not every specific active topical agent may be discussed in detail but a few general principles can be stated. Bacterial infections of the skin are best treated with systemic antibiotics, but localized areas of impetigo can be effectively treated with *topical antibiotics* alone. These in general have the disadvantage of being supplied in greasy ointment bases and therefore will not allow the needed drainage.

Neosporin® lotion and aerosol sprays circumvent the objection of excessive greasiness and are therefore more useful. Some topical antibacterial agents should not be used since they lead to sensitization in a high percentage of instances. These include penicillin and sulfonamide ointments. If skin sensitization is caused, the patient cannot later take these drugs systemically. If they are used without mishap there is no greater danger of skin eruption if given systemically.

Seventy per cent isopropyl alcohol has many advantages as a *topical skin antiseptic* for office or operating room use. It rapidly kills surface organisms, except spore forming ones, and is economical. Quaternary ammonium compounds, especially if in aqueous solution, are poor degerming agents for topical use.

SKIN DISEASES / Osment

The most widely used and safest *antipruritics* contain counterirritants such as menthol, phenol, or solution of coal tar. A useful soothing lotion can be made with equal parts of Nivea skin oil® and calamine lotion with the addition of one-half per cent menthol.

Topical Anesthetics

Most *topical anesthetics* have too high a sensitizing rate to be useful. Lidocaine, Nupercaine®, and Benzocaine® should be avoided. The same is true of most antihistamines when used topically. There are several satisfactory topical anesthetics with low sensitizing indices, they include Quotane®, Dyclone®, and Tronothane®.

Preparations containing *tars* are less widely used at the present than in past decades. Tars have an anti-eczematous action of obscure mechanism. They are especially useful in psoriasis but are also beneficial in chronic eczematoid eruptions. Crude coal tar ointment (three to six per cent) is used in both types of conditions. Better tolerated but perhaps not quite so effective are the various refined coal tar ointments, creams and lotions; for example Tarbonis®. Refined tars are available as combinations with corticosteroids. These are used frequently in the Saran Wrap® technique.

Pragmatar® which contains refined tar, salicylic acid, and precipitated sulfur in a water miscible base is a most useful topical for the treatment of chronic interdigital tinea pedis. It is more effective and less irritating than ointments containing undecylenic acid.

Corticosteroid Topicals

Corticosteroid topicals are available in a variety of vehicles, strengths, sizes and mixtures. Ointments, creams, aerosol sprays, foam aerosols, and lotions can be obtained. Antibiotics, antifungals, tars, and

antiseborrheics are frequently added. Topical corticosteroids are safe and effective. When in doubt, use them, they will rarely cause any harm. Systemic effects from topical corticosteroids are not a problem and infections will not be enhanced by topical steroids. In fact, in acute dermatophytosis of the feet they are very helpful antiinflammatory agents.

One of the most common disorders for which medical advice is sought, is *seborrheic dermatitis*. Medications containing elemental sulfur are widely and effectively used for this condition. Shampoos containing sulfur include Fostex®, and Proseca®. Sulfide salts of metals are found in Capsebion® and Selsun® shampoos. Detergent shampoos like Alvinine® are also effective. The first rule in the treatment of seborrheic dermatitis of the scalp is frequent shampooing; daily for men and twice weekly for women. *Acne medications* contain commonly sulfur, resorcinol, or salicylic acid and are meant to be drying and peeling. Marginal blepharitis or seborrheic dermatitis of the lid margins are effectively treated with sodium sulfacetamide (Sulamyd®, Metimyd®).

Summary

Many skin diseases can be treated effectively with topical therapy alone. Others require combined systemic and topical therapy. In either case proper topical therapy depends first on making the proper diagnosis and then on a knowledge of the properties of the preparation to be used.

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4. Sulzberger, Marion B., and Wolf, Jack: *Dermatologic Therapy in General Practice*, Chicago, The Year Book Publishers, 1948. 663 p.

AMA INSTITUTE SETS RECORD ATTENDANCE

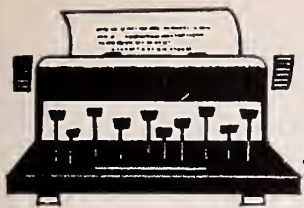
Record attendance of State and County Medical Society officers and executive secretaries proved the worth of the annual American Medical Association Institute convened on August 22-23, 1963, Chicago. This meeting is designed to cover projects, programs, problems and plans for organized medicine at the state and county levels.

Subjects discussed included the "Cost of Medical Care," the "Town and Gown Syndrome," a panel on "Making Health Insurance Work," and "Professional Relations with Voluntary Health Agencies."

Dr. F.J.L. Blasingame, AMA Executive Vice President, opened the two-day session with a talk on "Looking Ahead at the AMA" and AMA President, Dr.

Edward R. Annis, delivered the closing address of the program. Medical public relations was highlighted in a session devoted to "Accentuating the Positive — Reacting to the Negative."

Representing the Medical Association of Georgia at the meeting were Dr. J. G. McDaniel of Atlanta, MAG President-elect; Dr. John T. Mauldin of Atlanta, MAG Secretary; Dr. Linton Bishop, Atlanta, MAG Public Service Chairman; Dr. William Moore, Jr., Atlanta, MAG Insurance and Economics Committee and Mr. M. D. Krueger, MAG staff. Fulton County Medical Society was represented by Dr. Thomas Anderson, Atlanta, F.C.M.S. President-elect, and Dr. J. Frank Harris, Atlanta, F.C.M.S. Public Relations Chairman.



Exfoliative Cytology

THIS IS BECOMING an epoch in medicine. The detection, diagnosis and prognosis of malignancy by cytologic smear has been of such extraordinary value that the rate of salvage of cancer patients has been positively improved. The cytologic smear has also proved itself to be of great value in endocrinologic, physiologic, and biologic studies.

Papanicolaou

When one thinks of exfoliative cytology, the name of Dr. George N. Papanicolaou is automatically remembered and associated with this relatively recent giant's step in medicine. Forty years ago, in 1923, Papanicolaou first began his intensive study of vaginal smears in the human. For many years prior to this time he had shown particular interest in the cytologic study of the genital tract of experimental animals; building up a wealth of knowledge to be applied to his subsequent discoveries. While studying the vaginal smears of women with both normal and pathologic genital tracts, he found that, "it was easy to recognize the cancer cells." He later recorded that, "the first observation of cancer cells in a smear of the uterine cervix was one of the most thrilling experiences of my scientific career." He presented his first report "New Cancer Diagnosis" in 1928, in the Proceedings of the Third Race Betterment Conference.

Indifference and Skepticism

These findings, so clearly described and meticulously documented should have then caused a sensation on the medical scene. But instead the Papanicolaou observations met with indifference and skepticism as to their practical value. The time honored and proved way to diagnose cancer under the microscope was through altered tissue architecture, and living individual cells, showing long accepted changes in interrelationship, morphology, and environment.

Competent pathologists doubted that detached and dying cells could add anything of value to possibly improve cancer diagnosis. They practically refused to

listen to this relatively unknown alien from Greece. This serious rebuff and the frustrations that followed all but completely discouraged Papanicolaou. In the middle 1930's, his work dealt chiefly with the study of endocrinology by exfoliative cytology, although in 1932 he found two unsuspected cancers of the uterine cervix with vaginal smears. In the late 1930's, with his interest still unquenchable concerning the smear technique of the diagnosis of cancer, a fortunate meeting with Dr. Herbert F. Traut occurred. Dr. Traut was of the Department of Gynecology at the New York Lying-In Hospital. Grants were very difficult to obtain in those days when the world's interest was focused on the rapidly fulminating World War II, but through the Commonwealth Fund enough money was obtained to permit a thorough study of exfoliative cytology. This led to publication by George N. Papanicolaou and Herbert F. Traut of a monograph on their cancer detection studies. Published in 1943, it has become a milestone in the history of cancer detection, and as Papanicolaou had noted was, "the turning point in the attitude of the medical profession to Exfoliative Cytology." Now the flood gates of interest and research were opened, and from many sources there poured forth confirmatory and new evidence firmly substantiating this new tool for diagnosis and treatment of cancer.

In 1948, under the sponsorship of the American Cancer Society, the first Cytologic Conference was held in Boston, and today an examination in cytologic diagnosis is now required as part of certification by the American Board of Pathology. The knowledge of cytology gets firm emphasis in many other Specialist Board examinations and in the class rooms of all medical schools.

There now exists the constant effort to refine the technique of cell collection, staining and screening. Regardless of what criteria have been set forth for the study of and diagnosis of cancer, the ultimate diagnosis must come from the cancer cell itself. In the past ten years new and simpler stains have been introduced to save time and space. One of the most

encouraging techniques has been that of using fluorescent microscopy developed by Bertalanffy in which he uses a quick staining fluorescent dye and ultraviolet light. This is proving to be of great value in decreasing screening time but yet not compromising the accuracy of the interpretation.

It is fitting, therefore, on the twentieth anniversary of this milestone in American medicine that we should pay tribute to the Father of Exfoliative Cytology, Dr. George Papanicolaou, who passed away only two years ago. We are witnessing the development of a brilliant facet in a Golden Era of American medicine. The use of Exfoliative Cytology is a giant step toward the ultimate control of cancer.

John H. Ridley, M.D.

The Merits Of A Gift



"Realizing that people entering medicine are of good character and have good prospects, you lend money to them without the humiliation of trying to get co-makers, or of close control over the use of the funds. There is an interest rate to pay which restores even more respectability to the role of the borrower. But probably the greatest benefit to the student, and also the profession, is the feeling that he is doing it on his merits."

Oregon Medical Student

THE ABOVE QUOTE from a loan recipient states the ideal purpose of the American Medical Association Education and Research Foundation (AMA-ERF).

Conceived 18 months ago out of the realization that monetary support for medical education was inadequate, the AMA Loan Guarantee Program has attained creditable goals in the ensuing months. AMA-ERF has recently released its progress report, March 1962-June 1963, and the results make one wonder why such a program has not been implemented before.

Loans, secured by \$1 for each \$12.50 worth of credit, have averaged \$1,120 in principal amount. The minimum that can be borrowed is \$400 and the maximum is \$1,500 during any academic year. Loans to residents and interns have averaged slightly higher in amount of principal than those to medical students, although in number, 63 per cent of all loans have gone to medical students.

Support Renewed

Renewed support of the program from previous benefactors, together with new contributions in the first half of 1963, has made a total of \$18,164,260 in bank credit available for loans to medical stu-

dents, interns and residents as of June 30. Of this total, \$15,213,387 has already been extended (with approximately 60 per cent representing principal amount and 40 per cent estimated interim and payout interest) for nearly 8,000 loans approved since the program's inception in March, 1962, plus 291 loans in process as of June 30. This leaves a balance of \$2,950,873 in credit potential, secured by the uncommitted portion of \$236,070 in the Guarantee Fund, and this is sufficient to cover the principal and interest for about 1,600 additional loans.

To Meet the Criteria

Applicants must demonstrate a need for loan funds to meet essential training and living costs. The continued high level of demand, along with statements from borrowers on what their loans have meant to them, testify to the impact the program is making upon the problem of financing medical education and training.

Students from 84 medical schools, and interns and residents in training in 504 hospitals had borrowed through June 30. Fifty-two loans had reached the payout stage by June 30. Of these, ten were paid in full at maturity and the others were refinanced into payout loans. Borrowers are given the opportunity to

arrange refinancing calling for equal monthly payments over a maximum ten-year period. In addition, thirty-six loans were returned, and two were defaulted through death.

They Contribute

Individual physicians, medical societies, and private industry have continued their generous support, giving \$575,000 in the first half of 1963. Pharmaceutical concerns, insurance companies, and various medical affiliated societies and sororities have also

contributed a large share of the funds. Each month in *JMAG* a list of Georgians who have contributed to AMA-ERF is published. An entire page has often been devoted to Georgians who see the need for continued support of the program.

Because of its spectacular showing in the last year and a half, the AMA-ERF Loan Guarantee Program speaks for itself. The Doctor may speak for himself by sending \$1 for every \$12.50 to: *AMA-ERF, 535 North Dearborn St., Chicago 10, Illinois.*

Oxygen Therapy

OXYGEN IS A DRUG. It should not be administered to any patient except on the order of a licensed physician. This same requirement should be applied to the currently increasing devices designed for the administration of positive pressure ventilation. It should apply whether this positive pressure is produced by oxygen or by compressed air. Particularly it should apply when any drugs are administered by nebulization in conjunction with one of the IPPB devices.

Over recent months it has been rather appalling to find individuals who have been able to purchase both oxygen and the IPPB devices without reference to a licensed physician. Many times these items are purchased on the recommendation of a neighbor or of a salesman. Particularly in the field of chronic obstructive lung disease, the indiscriminate sale of both of these items can constitute a hazard to the patient's well being.

Harmful Effects Documented

The harmful effects of improperly administered oxygen in cases of emphysema have been well documented. Seldom a month goes by but that well-intentioned oxygen therapy causes the unnecessary or premature demise of such a patient. This happens even at the prescription of a physician, but it is certainly much more likely to occur if oxygen is freely available in supermarkets and drug stores. A question was raised several years ago regarding the advisability of long-range, continued intermittent positive pressure breathing therapy in chronic obstructive lung disease. It is the feeling of many physicians that these machines should be used only in the acute phases of disease and not for long term therapy.

These ideas may be subject to change as subsequent developments achieve greater control of the respiratory cycle, particularly in regard to the control of flow rates. The indiscriminate sale of the machines may well result in harmful effects to individual patients, as well as lack of accurate determinations of whether or not these machines are of value in long term therapy of chronic diseases.

Proven Effective

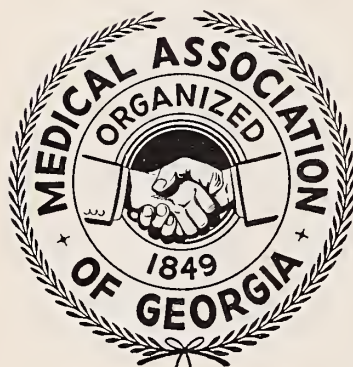
Drugs are commonly used in conjunction with intermittent positive pressure breathing devices. Many are of doubtful help and certainly many have possible harmful properties. It would be most unwise for any individual other than a physician to prescribe the drugs to be used in an IPPB device. This would be particularly hazardous in the case of an individual whose primary concern is the sale of a piece of equipment, although he should be able to recommend *to the physician* which agents have been proven most effective with his particular equipment.

Necessary Insurance

In consideration of the above, this statement is prepared to encourage those in the area of production and sale of this type equipment, and of oxygen, to take whatever steps are necessary to insure that both the oxygen and the IPPB devices are sold, rented, or otherwise provided to a patient only on the prescription of a licensed physician. It should not be necessary to obtain an "oxygen number" in order to prescribe these agents, but at the same time, these agents and devices deserve the consideration of becoming strict prescription items.

1964 Annual Session

May 3-6, 1964—Macon, Georgia



Last Call for Scientific Papers

All titles must be submitted to the
respective program chairmen listed
below before November 1, 1963

ANESTHESIOLOGY

Earl Avant, M.D.
781 Spring Street
Macon

CHEST

Sam E. Patton, M.D.
797 Poplar Street
Macon

DERMATOLOGY

Richard B. Ewing, M.D.
643 Orange Street
Macon

DIABETES

H. C. Atkinson, M.D.
724 Hemlock Street
Macon

GENERAL PRACTICE

Charles E. Bohler, M.D.
Box 8
Brooklet

HEART

Thomas L. Ross, M.D.
700 Spring Street
Macon

MEDICINE

Henry H. Tift, M.D.
765 Spring Street
Macon

OBSTETRICS AND GYNECOLOGY

Gordon W. Jackson, M.D.
740 Hemlock Street
Macon

OPHTHALMOLOGY AND OTOLARYNGOLOGY

W. D. Jarrat, M.D.
629 First Street
Macon

ORTHOPEDICS

L. Clyde Sheehan, Jr., M.D.
671 Hemlock Street
Macon

PATHOLOGY

Leonard Campbell, M.D.
548 First Street
Macon

PEDIATRICS

John Paul Jones, M.D.
885 Pine Street
Macon

PSYCHIATRY

Thomas M. Hall, M.D.
752 Hemlock Street
Macon

PUBLIC HEALTH

Robert J. Walker, M.D.
Macon-Bibb County Health Dept.
Macon

RADIOLOGY

Robert F. Cato
722 First Street
Macon

SURGERY

J. P. Woodhall, M.D.
724 Hemlock Street
Macon

UROLOGY

Robert W. McAllister
811 Orange Terrace
Macon

PRESIDENT'S LETTER

YOUR AMA

GEORGE R. DILLINGER, M.D.



WHAT IS the American Medical Association?

The AMA is a Federation of 54 State and Territorial Commonwealth Medical Societies.

The policy making body of AMA is the House of Delegates. The Delegates are elected by the constituent associations, according to the number of active AMA members in the constituent society. Also, each Scientific Section elects a Delegate as their representative. The three Military Medical Services and the U. S. Public Health Service each have one Delegate. The total number of Delegates for the 112th annual meeting was 227.

The House of Delegates decides policy and elects the officers of the AMA and the Board of Trustees. The Board of Trustees functions as the Executive body of the Association, limited by the policy decisions of the House of Delegates.

Democratic Organization

The House of Delegates is the most democratic organization in the world today. Any member of the AMA or any proper person introduced by a member, may appear and speak before a reference committee on any subject due consideration.

Membership in the American Medical Association is now at an all time high, 196,138, and growing at a faster rate than ever before.

Georgia Denied

Georgia is being denied its proper representation in the AMA. December 31, 1962, we were about 75 members short of having another Delegate and Alternate, making a total of four Delegates to represent us in the greatest medical forum of all time.

Why were 559 MAG members not members of the AMA? It must be due to lack of information. A dean of one of our medical schools was not a member of either MAG or AMA. Students of that

school do not affiliate with the Student American Medical Association. Why?

What does a physician lose by not participating and being an AMA member?

1. The most widely circulated medical publication in the world, the weekly *AMA Journal*.
2. His choice of any one of the ten AMA monthly specialty journals.
3. The fortnightly newspaper of American Medicine, the *AMA News*.
4. A reception room copy of *Today's Health*, monthly family health magazine.

The above subscriptions alone are worth far more than the dues paid. But that is only the beginning. Other services available to physician members are:

1. Admission to two great scientific sessions annually.
2. Question and answer consultation services on medical subjects thru the *AMA Journal*.
3. Scientific Information on new drugs, research, foods and nutrition, physical medicine, cosmetics, pesticides, poisons and other subjects.
4. Physicians' placement service and location information.
5. Practice Aids, including management information, medico-legal literature and office planning suggestions.
6. Annual lists of internships and residencies offered.
7. Lists of postgraduate courses offered throughout the country.
8. Pamphlets on hundreds of health educational subjects.
9. Bibliographies and information on types of medical practice.
10. Medical films on loan to supplement scientific and health talks.
11. Standardized insurance forms.

PRESIDENT'S LETTER / Continued

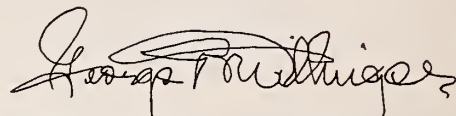
12. Doctor-Patient relations educational materials.
13. Up-to-date information on suspected quacks and quackery.
14. Information and council about physicians special medico-legal problems.
15. Library reference service and materials on request.
16. Available group disability insurance for members with lifetime benefits.

17. AMA new dictionary style handbook of disease nomenclature, "Current Medical Terminology."

18. The AMA Directory Service.

In addition to the above services for physicians, there are uncounted public service programs of the AMA that benefit only Mr. and Mrs. U. S. A. and their children.

How can any physician worthy of the name, not be a member of the AMA?



President, Medical Association of Georgia

MEDICAL COLLEGE ANNOUNCES OPENING OF MODERN NEW LIBRARY

A new \$670,000 library has been opened on the campus of the Medical College of Georgia. It is expected to become the major reference center for physicians throughout Georgia, and is planned to meet library requirements for the next quarter-century.

Space Capacity

The new two-story structure provides stacks for more than 100,000 volumes and includes space for hundreds of scientific periodicals, many files of which are complete. In addition, the library has seating accommodations for 300 persons in conference rooms, individual study carrels, and general reading areas.

The modern, clean-cut lines of the glass and brick building, with its walled garden, are impressive as well as inviting. The decor of off-white, rust, dark gray and gold, with accents of blue, is colorful but not gaudy. Electronic air purification, air conditioning, fine lighting and gray-tinted glass provide physical comfort.

A unique feature of the Library is the "Rare Books" room with walnut panelled walls and red carpeted floor, fireplace and chandelier. In this setting, the bibliophile may examine the 1608 edition of Avicenna's "Arabum Medicorum." Or, if his interests run to the metaphysical and bizarre, the "Opera Omnia" of Paracelsus may attract him. Also in the rare book files is the field manual of the Confederate Army, of which Dr. Henry Fraser Campbell of the Medical College of Georgia was one of the editors. Readers who lean toward medical "firsts" will want to read the original of Beaumont's "Experiments and Observations on the Gastric Juice and the Physiology of Digestion," or Laennec's "Diseases of the Chest."

Interesting History

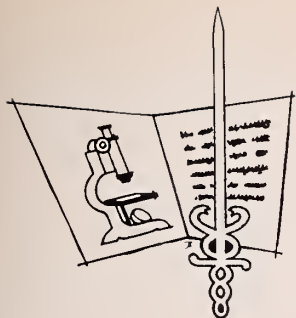
The Medical College Library has had a long and interesting history. In 1834 the faculty, consisting of six members, raised six thousand dollars and sent Dr. Louis Alexander Dugas (one of the founders of the school) to Europe to buy laboratory equipment and books for a medical library. The majority of his books are still intact.

To Meet the Needs

In recent years, as the academic and research programs of the college have expanded, a coincidental growth of library holdings has taken place. In order to meet the study needs of students in medicine, nursing, graduate education, medical technology, medical illustration, medical records library science, and other paramedical fields, the need for a centralized health sciences library grew more and more apparent. Preliminary plans for the present library structure began in 1959. Ground was broken in January, 1962, and the completed building was accepted by the building authority of the Board of Regents this Spring.



The new Medical College of Georgia Library, with its large holdings of medical books and scientific journals, is an attractive addition to the campus. Its facilities are available to both medical students and physicians throughout Georgia.



THE ROLE OF RADIATION THERAPY IN THE MANAGEMENT OF MALIGNANT DISEASES

Bryan L. Redd, Jr., M.D., *Atlanta*

WITH THE standardization and more universal acceptance of approved systems of clinical classification of many of the leading types of malignant diseases, the effectiveness of various treatment methods can be evaluated. The role which radiation therapy may occupy in the management of a malignant process will depend upon several factors: 1. Anatomical site of primary, 2. Clinical stage or extent of involvement, 3. The existence of complicating factors, 4. Previous forms of treatment, and 5. The patient's general health. The purpose of treating a patient will be either *Curative* or *Palliative*.

Curative

In the *Curative* group, the goal of the treatment is to completely eradicate the malignant process, thus permitting the patient to continue with normal activities for an average life expectancy. Radiation therapy has proven to be a curative form of treatment in primary malignancies arising from the skin, uterine cervix, naso- and oropharynx, and larynx. The control rates in these primary sites are greatly influenced by the clinical stage of the disease when treatment is instituted. For example, in lesions of the uterine cervix, the control rate for Stage I is 80 + per cent, while in Stage IV, it is only ten per cent. Not infrequently, prolonged control may be effected in primary lesions of the lung, esophagus, ovary, colon, and bone. In the treatment of certain malignancies, radiation therapy may be used in conjunction with surgery, thus resulting in a higher control rate than could be obtained by either modality alone. Pre-operative irradiation has proven helpful in the management of malignant lesions of the endometrium, colon, lung, advanced lesions of the oropharynx, and in selected cases of carcinoma of the

breast. Post-operative irradiation is useful in the management of lesions found to be inoperable or incompletely removed (colon, ovary, breast, and lung.)

Palliative

In the more advanced or recurrent cases, eradication or control of the disease is impossible; however, prolonged restraint of the malignant process may be effected in certain cases. The objective of *Palliative* treatment is the alleviation of pain, reduction of obstructions, delay or effective absorption of effusions into the thoracic or abdominal cavities, and reduction of the risk of pathological fracture. The irradiation dose given in palliative treatment is generally less than the dose given in curative treatment; however, the treatment may require greater attention to technical details and clinical course because of associated conditions which may affect the patient's ability to tolerate the treatment.

Diverse Knowledge

The planning and supervision of irradiation therapy requires a knowledge of many diverse subjects: 1. The biologic nature of the disease process, 2. The anatomy of the primary site and its lymphatic pathways, 3. The irradiation tolerance of the normal tissue in the region involved, 4. The types of operative procedures which may be performed in this region and the resulting alterations of normal anatomical relationships when performed, 5. The physics and mathematical equations of radium, X-ray and radioactive isotope therapy, thus permitting a proper blend of various forms of irradiation therapy in the appropriate anatomical region. Unlike oral or parenteral medications which become absorbed into the blood stream and circulate throughout the body,

CANCER PAGE / Continued

irradiation effects are confined essentially to the volume of tissue in the treatment area. In the treatment of carcinoma of the skin or vocal cord, the volume of tissue treated is very small, while in the treatment of carcinoma of the ovary, very large volumes must be exposed. When large volumes are treated, a drop in blood count and nausea may occur.

Higher Voltage

With the advances in the fields of metallurgy, glass blowing, electronics, and the development of better dielectric materials, X-ray therapy units operating at higher and higher voltages have been perfected. In the past decade, radioactive cobalt therapy units have become available. X-ray therapy units which operate at energies from one to three million volts, and the cobalt units produce less skin reaction

than conventional X-ray therapy, when full curative doses are given. This supervoltage range of irradiation delivers a higher tissue dose to deeply located lesions, thus improving the chances of a curative effect.

Rising Salvage Rate

With the refinement of therapy equipment and the associated development of antibiotics, safe transfusion techniques, and other supportive medical procedures, there has been a steady increase in the salvage rate in many of the major types of malignant diseases. Since there is a rapid drop in control rates with advances in clinical stages of all malignant lesions, it behooves all physicians to be alert for signs or symptoms which may lead to the earlier detection of these lesions, and to seek the best form or combinations of treatment to produce optimum control.

401 Peachtree Street, N.E.

Approved by Professional Education Committee, Georgia Division, ACS.

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA FOR JULY, AUGUST, 1963

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Cohen, Larry A.	80 Butler Street, N. E. Atlanta 3, Georgia	Active	Fulton
Cooper, Floyd R., Jr.	1009 N. Monroe Street Albany, Georgia	Active	Dougherty
Davis, Albert M.	239 Auburn Avenue, N. E. Atlanta 3, Georgia	Active	Fulton
Dickinson, John I.	14 Hospital Circle Rome, Georgia	Active	Floyd
Husseini, Majed W.	Houston County Hospital Warner Robins, Georgia	Active	Peach Belt
Hester, Keith	Floyd Hospital Rome, Georgia	Active	Floyd
Jaicks, John R.	1540 Watson Boulevard Warner Robins, Georgia	Active	Peach Belt
Marlow, James E.	Cleveland Highway Dalton, Georgia	Active	Whitfield
Meacham, Jack R.	Chatsworth, Georgia	Active	Worth
Palmer, James D.	956 Hunter Street, S. W. Atlanta 14, Georgia	Active	Fulton
Rothenberg, Marvin B.	300 Boulevard, N. E. Atlanta 12, Georgia	Active	Fulton
Tindall, Harry C.	1938 Peachtree Road, N. W. Atlanta 9, Georgia	Active	Fulton
Turk, L. Newton, III	1293 Peachtree Street Atlanta 9, Georgia	Active	Fulton



EVALUATION OF CHANGES IN THE PULMONARY CIRCULATION BY CHEST RADIOGRAPHY

Brit B. Gay, Sr., M.D., *Atlanta*

ROUTINE FRONTAL and lateral radiographs of the chest can give to the physician much detailed information concerning physiologic changes in the pulmonary circulation when the film is properly interpreted.

Arteries and Veins

In the normal PA roentgenogram of the chest, the lung markings are produced primarily by the pulmonary arteries and veins. The bronchial arteries and veins and the lymphatic structures contribute very little to the linear shadows seen in the chest roentgenogram. The upper portions of both hilar shadows are predominantly produced by pulmonary veins branching from the superior pulmonary veins which empty into the left atrium. The inferior portion of the hilar shadow is predominantly made up of the descending pulmonary arterial branches which are continuations of the main pulmonary artery on either side. The inferior pulmonary veins are visualized near the heart shadow and are more medial and more horizontal than are the arterial structures. The determination of the type of vascular shadow, whether arterial or venous, is made primarily by anatomical position of the shadow rather than by any radiographic characteristic.

The greatest information is obtained when one considers the chest radiograph in relation to physiologic changes in the pulmonary circulation, particularly in patients with heart disease. Though the causes of any physiologic state may be many, the basic pulmonary vascular pattern is essentially the same regardless of etiology. The more common pulmonary vascular patterns will be described.

When the pulmonary venous pressure is elevated, there first occurs dilatation of the pulmonary venous shadows. Initially this involves both inferior and

superior pulmonary veins, but in a more chronic and prolonged process such as mitral stenosis the dilatation is seen in the superior pulmonary veins in the upper lung fields with associated constriction of the inferior pulmonary veins. This pattern usually indicates a pulmonary venous pressure greater than 18 mm. of mercury. As the pulmonary venous pressure is elevated further, there occurs extravasation of fluid into the interstitial tissues of the lungs. This interstitial edema is manifested on the chest film by the presence of linear densities in the costophrenic angles known as septal lines or Kerley's lines. These lines represent accumulation of fluid in the interlobular spaces of the lung between the secondary pulmonary lobules. These lines are not evident unless there is some process increasing their thickness. Septal lines may result from edema fluid, tumor infiltrates, fibrosis, and distended lymphatics related to lymphatic obstruction. Because of the accumulation of edema fluid around the vessels in the perivascular spaces, the pulmonary vascular shadows become hazy. This is referred to as pulmonary clouding and is seen in any cause of pulmonary venous hypertension provided the pressure elevation is in the range of 20 or 25 mm. of mercury. When the edema fluid is extravasated into alveolar spaces, the lung pattern takes on a more solid density since the air content in the alveolar spaces is obliterated by the fluid. This is frequently seen in acute pulmonary edema from any cause as central butterfly consolidation involving the middle third of the lung fields. Fluid accumulating in the subpleural tissue spaces may produce increased thickness and visibility of the interlobar fissures. In time, there is associated with pulmonary venous hypertension secondary arterial hypertension. As the pulmonary artery pressure elevates, the central pulmonary arterial trunks dilate more prominently.

A good index to the size of the pulmonary arteries is that of the right descending pulmonary artery branch in the right hilar area. In the normal adult this vessel has a transverse diameter of nine to 15 mm. The central arterial trunks are usually dilated in most cases of left heart failure from any cause.

Pulmonary Arterial Hypertension

When there is elevation of the pulmonary systolic arterial pressure above 50 mm. of mercury, there occurs dilatation of the central pulmonary arteries. When the pulmonary arterial hypertension is due to obstruction in the pulmonary vascular bed at a capillary or precapillary level, changes in the radiograph are those of marked dilatation of the central pulmonary arterial trunks in association with rather prominent constriction of the more peripheral branches. The arterial tree has a pruned appearance on the chest roentgenogram. There is no pulmonary venous dilatation when precapillary pulmonary arterial hypertension is present. Pulmonary venous dilatation will be present only when the pulmonary venous pressure rise precedes the arterial pressure rise. Pulmonary arterial hypertension from any cause will have a similar pattern on the chest roentgenogram.

Increased Pulmonary Blood Flow

In the presence of left-to-right shunts such as ventricular defect, atrial defect, and patent ductus arteriosus, there occurs increased circulation of blood through the pulmonary vessels since part of the systemic output is shunted through the congenital defect back into the right side of the heart or pulmonary circulation. This overcirculation of the pulmonary vascular bed is manifested on the routine roentgenogram of the chest by marked dilatation of the arterial and venous structures of the lungs both centrally and peripherally. The most marked increase in vascular prominence is seen in atrial septal defect and very large ventricular septal defects. Less striking change is seen in patent ductus arteriosus. The evaluation of the pulmonary blood flow is perhaps the most important contribution of the radiologist in the diagnosis of congenital heart disease. An additional aid in determining increased pulmonary blood flow is obtained from fluoroscopic observation of the pulsations in the pulmonary arteries centrally and peripherally with the fluoroscopic image amplifier. With an increase in pulmonary blood flow there is an associated increase in the intrinsic pulsatile activity of the central and peripheral pulmonary artery branches in the lung. In patients having borderline vascular changes in the chest roentgenogram, fluoroscopic study of pulsations will be of immense value

in proving the presence of a moderate increase in pulmonary blood flow. The pulsations which are usually increased in prominence with the pulmonary blood flow are about two times the systemic blood flow.

Decreased Pulmonary Blood Flow

In those cyanotic congenital defects where the blood from the right side of the heart is directed away from the pulmonary circulation directly into the left side of the heart and aorta thus bypassing the pulmonary circulation, there occurs a relative decrease in the blood volume passing through the pulmonary circulation in relation to that passing through the systemic circulation. In this group of right-to-left shunts, Tetralogy of Fallot would be the most classic example. The vascular pattern on the chest roentgenogram is just the reverse of the previously described "increased flow" group. The pulmonary arteries and veins are small and the lungs show diminution of the vascular markings throughout. Pulsations of the pulmonary arteries are absent at fluoroscopy.

Accessory Bronchial Collateral Circulation to the Lung

When there is atresia to the pulmonary valve or main pulmonary artery, no blood can reach the lungs from the right ventricle. In this situation the bronchial arteries enlarge and supply the lungs with blood. These bronchial arteries anastomose with smaller pulmonary artery branches within the lung. When this situation is present, there is a change in the vascular pattern on the chest roentgenogram. The vascular markings have a very irregular distribution. The vessels that are visualized are small in size but tend to be very numerous. At fluoroscopy no pulsations are evident in these vessels. There is a lack of visualization of the central pulmonary arterial shadows connecting the hilar density with the mediastinum due to a lack of the presence of the main hilar pulmonary artery branches. The hilar vascular shadow tends to be isolated away from the mediastinal border as an island of irregular vascular channels.

Asymmetrical Vascular Markings

Asymmetry in the prominence of the pulmonary vascular shadows should be looked for. There are several congenital and acquired lesions which produce a deficiency in the vascular markings in one lung in association with an increased prominence of the vascular shadows in the other lung. The congenital lesions would include atresia of the left or right pulmonary artery, severe coarctation of the right or left main pulmonary arteries, hypoplasia of one lung, and type II truncus arteriosus where one

pulmonary artery arises from the aorta and the other pulmonary artery is absent with the lung being supplied by the bronchial circulation. Certain acquired lesions may produce differences in vascularity between the two lungs. There have now been reported a number of patients surviving with thrombosis of a main pulmonary artery. Severe lung disease such as bronchiectasis may be associated with a decrease in the normal pulmonary arterial supply to the involved lung. Pulmonary emphysema will also show decrease vascularity on the involved side if the process is unilateral.

There have now been reported a number of cases of congenital pulmonary venous obstruction either unilaterally or bilaterally. The pulmonary veins to one lung may be severely stenosed or even atretic so that the drainage of blood from the involved lung must be to an anomalous route. Congenital pulmonary venous obstruction usually produces severe interstitial fibrotic change within the lungs with a con-

traction of the involved lung. The lungs show diffuse septal line formation and there is a shift of the mediastinum toward the involved side.

Pulmonary Vascular Anomalies

Certain anomalies of the pulmonary circulation can be suspected by the plain roentgenogram of the chest. Pulmonary arteriovenous fistula of the lung produces multiple nodular densities within the lung sometimes simulating metastatic disease. Angiocardiography will be diagnostic. Pulmonary artery coarctation can occur in the smaller branches of the lungs and may produce visible narrowing of the arterial shadows.

From information gained by angiocardiography and cardiac catheterization much has been learned about the assessment of the pulmonary circulation with the routine chest roentgenogram, and many physiologic states and disease processes can be more accurately predicted.

Emory University School of Medicine

Prepared at the Request of the Committee on Professional Education of the Georgia Heart Association.

THOMASVILLE WILL HOLD SECOND MEDICAL SEMINAR

Four out-of-state guest speakers have been slated for the Second Annual Thomasville Medical Seminar to be held Thursday and Friday, December 5-6, 1963, at Thomasville, Georgia.

Eleven hours credit, Category one for General Practice has been approved. Each of the four speakers will give a 45 to 50 minute lecture each day and there will be question and answer sessions lasting approximately one to one and a half hours following each day's session.

Guest Speakers

The guest speakers and their subjects will be Richard TeLinde, M.D., Professor Emeritus of Gynecology, Johns Hopkins University: (1) Indications for pelvic surgery, (2) Urinary incontinence in women; Davis Boyd, M.D., Senior Surgeon for the Lahey Clinic: (1) Conservation and operative treatment of hiatus hernia, (2) Management portal hypertension with bleeding; George Cahill, Assistant Professor of Medicine at Harvard University: (1) Newer concepts

in pathogenesis, diagnosis and treatment of diabetes, (2) Adrenal insufficiency, diagnosis and treatment; and Nathan Smith, M.D., Chairman of the Department of Pediatrics, University of Wisconsin: (1) Iron metabolism and iron deficiency anemia in early life, (2) The child that bleeds.

Planned Recreation

There will be planned activities for the ladies, and on Saturday, December 7, following the meeting, recreation and activities consisting of a Golf Tournament and a possible Tour of the Plantations and a Skeet Shoot will be held. The guest lecturers will be entertained with a Quail Shoot on Saturday morning. Thursday night, December 5, a social hour, banquet and dancing will be held for all participants.

For further information concerning the Seminar contact: George M. Lane, M.D., John D. Archbold Memorial Hospital, Thomasville, Georgia.

FISKE ESSAY TO BE ON ENZYME CHEMISTRY

The Trustees of America's oldest medical essay competition, the Caleb Fiske Prize of the Rhode Island Medical Society, announce as the subject for this year's dissertation "CLINICAL APPLICATION OF NEWER DISCOVERIES IN ENZYME CHEMISTRY". The dissertation must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of

\$500 is offered. Essays must be submitted by December 11, 1963.

For complete information regarding the regulations write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

1963-64 CALENDAR OF MEETINGS

State

October 22-24—"Fractures in General Practice" sponsored by the Department of Continuing Education, The Medical College of Georgia, Augusta.

December 5-6—Fifth Annual Postgraduate Course in Ophthalmology of the Emory University School of Medicine, Grady Memorial Hospital, Atlanta.

January 14-16, 1964—"Thirteen Cardiacs" sponsored by the Department of Continuing Education, The Medical College of Georgia, Augusta.

February 10-14, 1964—"Hypertension and Its Complications" sponsored by the Department of Continuing Education, The Medical College of Georgia, Augusta.

February 18-20—"Obstetric Problems in Private Practice" sponsored by the Department of Continuing Education, The Medical College of Georgia, Augusta.

May 3-6, 1964—110th Annual Session of the Medical Association of Georgia, Macon, Ga.

Regional

October-November, 1963—Postgraduate Courses offered by the Department of Continuing Education of the University of Tennessee Medical Units: October 28-30—"Pediatric Hematology;" October 30-November 1—"Allergy;" November 6-8—"Emergency Surgery—Acute Injuries."

October 17-19—Symposium on Orthopedics, Trauma, Minor Surgery, and Office Orthopedics, Mound Park Hospital Foundation, Inc., St. Petersburg, Fla.

October 20-23—American College of Gastroenterology, Shoreham Hotel, Washington, D. C.

October 27—Association of Clinical Scientists, Statler-Hilton Hotel, Washington, D. C.

November 2-6—American Orthotics and Prosthetics, Jung Hotel, New Orleans, La.

November 7-9—Conference on Obstetric, Gynecologic, and Neonatal Nursing sponsored by District Four, Washington, D. C.

November 8-9—Southern Society for Pediatric Research, St. Jude Hospital, Memphis, Tenn.

November 17-18—Twentieth Annual Meeting of The Southern Chapter of the American College of Chest Physicians, Monteleone Hotel, New Orleans, La.

November 18-20—Medical Society of District of Columbia, Washington, D.C.

November 18-21—Southern Medical Association, New Orleans, La.

December 7-8—International Symposium on Hemophilia, Sheraton-Park Hotel, Washington, D.C.

December 9-10—American Society of Hematology, Statler Hotel, Washington, D.C.

December 10-12—Southern Surgical Association, The Homestead, Hot Springs, Va.

January 5-8, 1964—First Annual Postgraduate Seminar in Anesthesiology sponsored by the University of Miami and University of Florida Schools of Medicine, Miami Beach, Fla.

January 13-17, 1964—Postgraduate course sponsored by the American College of Chest Physicians on Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, Miami Beach, Fla.

January 27-29, 1964—American College of Surgeons, Lord Baltimore Hotel, Baltimore, Md.

February 12-16, 1964—American College of Cardiology, Roosevelt Hotel, New Orleans, La.

February 29-March 6, 1964—American College of Allergists, Americana Hotel, Bal Harbour, Fla.

National

September 15, 1963-June 15, 1964—Nine month tutorial program in Cardiology offered by the Institute for CardioPulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

October 21-25—Postgraduate course sponsored by the American College of Chest Physicians on Clinical Cardio-Pulmonary Physiology, Chicago, Ill.

October 24-30—Association of American Medical Colleges, Sheraton-Chicago Hotel, Chicago, Ill.

November 11-15—Postgraduate course sponsored by the American College of Chest Physicians on Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, New York City.

November 18-20—Tenth Symposium, "Aging of the Lung: Perspectives," sponsored by the Hahnemann Medical College and Hospital, Sheraton Hotel, Philadelphia, Pa.

November 21-23—American College of Physicians' First Sectional Meeting (Midwest), Detroit, Mich.

December 1-4—American Medical Association Clinical Meeting, Memorial Coliseum, Portland, Ore.

January 6-March 14, 1964—Ten week Postgraduate course in Tropical Health sponsored by the Stanford University School of Medicine, Stanford Medical Center, Calif.



RECENT PROGRESS IN GEORGIA

INSURANCE COVERAGE OF MENTAL ILLNESS

ONE OF THE discriminations against people who are mentally ill has been the failure of many commercial insurance companies and Blue Cross-Blue Shield organizations to provide hospitalization and/or medical fee insurance benefits by means of specific exclusions or by arbitrary clauses which are not applicable to the usual medical and surgical illnesses. Furthermore, some of these methods and pet clauses have not been clearly advertised or explained to the insured. Therefore, glaring injustices and disappointments have resulted.

Credit Given

National and state mental health associations, medical and psychiatric groups, psychiatric hospitals and many of our national and state officials have spoken firmly against this gross unfairness. Credit must be given, however, to a number of commercial companies and some Blue Cross-Blue Shield groups, who have not been a party to these discriminatory practices and who have always given equal coverage to patients with mental illness. More progress in this area of health insurance has been made recently in other states and it is now gratifying to know that similar strides for better insurance coverage of mental illness are being made in Georgia.

Resolutions by the Georgia Mental Health Association and the Georgia Psychiatric Association, and supported by the Medical Association of Georgia, have resulted in efforts by our Comptroller General and Insurance Commissioner, the Honorable James L. Bentley, to eliminate all discriminations.

Problem Studied

Shortly after he assumed office in January, 1963, Mr. Bentley initiated the formation of a committee to study the problem of pre-payment health insurance for mental illness in Georgia. The organizations represented on this committee were the state med-

ical, psychiatric, mental health and hospital associations; the State Division of Mental Health, Emory University Department of Psychiatry, as well as commercial insurance companies, Blue Cross-Blue Shield of the Atlanta area, and the Insurance Department of the State of Georgia. On July 1, 1963, the following report of this Study Committee was presented to Mr. Bentley:

1. "Mental illness as herein defined shall include those diagnoses as listed in the 'Diagnostic and Statistical Manual — Mental Disorders', published by American Psychiatric Association;
2. That all pre-payment health insurance carriers doing business in Georgia be requested to provide coverage for mental illness on a basis equal to that provided for any other illness;
3. That basic coverage for mental illness be made available in all individual and group contracts;
4. That this basic coverage for mental illness also be made available for dependents if it is desired;
5. That insurance plans shall cover treatment of mental illness in qualified psychiatric hospitals as well as in general hospitals;
6. That a qualified psychiatric hospital shall be defined as: An institution which, for compensation from its patients and on an in-patient basis, is primarily engaged in providing diagnostic and therapeutic facilities for diagnosis and treatment of mental illness or nervous disorders by or under the supervision of a staff of duly licensed doctors of medicine who are Board qualified in psychiatry or are Members or Fellows of the American Psychiatric Association, which continuously provides twenty-four (24) hour-a-day nursing

service by registered graduate nurses, and which is not other than incidentally: a nursing home, a place for rest, the aged, drug addicts, alcoholics, or for the treatment of pulmonary tuberculosis; and,

7. That there should be some supervision as soon as possible for the mutual protection of the insured and the insurer by a joint committee of the Medical Association of Georgia and insurance companies."

This report has received Mr. Bentley's endorsement. He urges all citizens to review their health insurance policies and to insist that equal coverage is provided for mental illnesses. His office has also passed this information along to local and national health insurance carriers who do business in Georgia.

Insistence

As physicians and interested citizens, we can also encourage—and even insist on—the full coverage of mental illness equal to that of any other illness and in any qualified hospital, by all individual and group insurance policies when written or renewed. By publicizing this to all business concerns and employers, they in turn can be certain that their insurance programs will fulfill this need rather than discriminate against it.

In a recent report by the Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, an excellent

review is presented titled, "Insurance Coverage of Mental Illness, 1962." The summary of this report concludes with the following statement:

"With the current trend toward shorter hospital stays and with increased actuarial experience indicating that coverage of mental illness would not increase hospital insurance costs substantially, it may soon be possible to have such coverage for inpatient care on the same basis as for physical illness. For outpatient care, more complete coverage will probably have to await additional actuarial experience. But the data starting to accumulate indicate that the number of persons seeking psychiatric care has been smaller than many people expected. Important groups, including the American Medical Association and the Special Governors Conference on Mental Health in November, 1961, have gone on record in support of insurance coverage of mental illness."

More recently President Kennedy stressed the importance of health insurance benefits for mental illness as was done at the 1963 meeting of the Southern Governors Conference. With shortage of personnel, hospital and community mental health facilities for the medically indigent, adequate pre-payment coverage for mental illness, and in turn private treatment, would lessen the demands on public facilities and save many tax dollars.

If this health service is not provided by private funds and health insurance benefits, it will then very likely come from the Federal Government. Therefore, let us help "sell" insurance coverage for mental illnesses.

Prepared at the request of the Sub-committee on Mental Health of the Medical Association of Georgia.

CONGRESSMAN WILL ADDRESS DISASTER MEDICAL CARE MEETING

An address by a ranking member of the House Armed Services Committee and a series of workshops on civil defense problems will be features of the 14th National County Medical Societies Conference on Disaster Medical Care.

The Conference, sponsored by the American Medical Association's Council on National Security, will be held November 2-3 at the Pick-Congress Hotel in Chicago. The meeting is designed for medical and health personnel concerned with disaster preparedness programs.

Rep. F. Edward Hebert (D., La.) the House committee member and chairman of its subcommittee which considers civil defense legislation, will speak at a luncheon session on Sunday, November 3, discussing Civil Defense in the U. S.

The workshop meetings will be from 2-5 p.m. Saturday, November 2, and cover the following topics: com-

munity health service planning, mass casualty care, hospital planning, training and utilization of allied personnel, medical education for national defense, civil defense emergency hospitals, and coordination of the medical effort with other aspects of civil defense.

Two symposiums on planning and resources are scheduled for Saturday morning's opening session. A third symposium dealing with AMA and government activities in civil defense and disaster care will be held Sunday morning.

Saturday's luncheon speaker will be Lt. Col. Richard L. Coppedge, MC, surgeon for the Special Warfare Center, Ft. Bragg, N.C. He will discuss the Medical Role in the Special Forces.

Additional information and advance registration are available from the Council on National Security, AMA, 535 North Dearborn St., Chicago 10, Illinois.

Wilmer, Grant, M.D., 384 Peachtree Street, N.E., Atlanta 8, Georgia, "Postpartal Heart Disease," Southern M.J. 56:803-811 (July 1963).

Myocardial degeneration of unknown cause occasionally occurs several weeks after delivery. Nine such cases are presented with the discussion of the clinical picture, the pathology and possible etiological factors. At present, the cause of such cases of myocardial degeneration remains unknown and one can only speculate as to whether these cases of myocarditis occur by chance in the postpartum period or whether some specific factor in pregnancy plays a part in their etiology.

Asada, Makoto, M.D., and John T. Galambos, M.D., 69 Butler Street, S.E., Atlanta 3, Georgia, "Liver Disease, Hepatic Alcohol, Dehydrogenase Activity, and Alcohol Metabolism in the Human," Gastroenterology 45:67-72 (July) 1963.

Hepatic alcohol dehydrogenase (ADH) activity in general was lower in patients with parenchymal liver injury than in normals. However, the magnitude of the decrease was not correlated directly with the extent or the severity of liver injury as judged by clinical or morphologic criteria.

There was no relationship between hepatic alcohol dehydrogenase activity and the rate of alcohol metabolism (mg/dl/hr) when it was administered intravenously.

There was no apparent impairment of the rate of alcohol metabolism in patients with acute and chronic active liver disease who could be biopsied as compared with normals. Although none of the patients tested was moribund, most of them with liver disease were jaundiced and active cell necrosis was demonstrable on liver biopsy.

There was no relationship between the quantitative histochemical estimation of ADH activity and the biochemically determined ADH activity of the same liver specimen. These two methods may complement each other, but they cannot be used to substitute each other.

Thoroughman, J. C., M.D., Veterans Administration Hospital, 4158 Peachtree Road, N.E., Atlanta 19, Georgia, "Changing Concepts of Peptic Ulcer," J. Nat. M.A. 55:306-308 (July) 1963.

Diocles of Carystos in 350 B. C. and Matthew Baillie in 1799, described some of the clinical features of peptic ulcer. Pavlov, Ekins, Dragstedt, Zollinger, and others have added to the knowledge of physiology and pathogenesis. Doyen in 1893, performed gastroenterostomy for pyloric stenosis resulting from ulcer. Modifications of surgical procedures were inspired by the shortcomings of previous operations. Apparently subtotal gastrectomy is being supplanted by vagotomy associated with pyloroplasty, 20 per cent resection or 50 per cent resection.

No unanimity of opinion has been reached regarding indication for surgery in gastric ulcer, but earlier sur-

gery seems gaining in popularity. When cancer is found histologically in a "benign" gastric ulcer, the five-year survival rate exceeds 40 per cent.

Ol has demonstrated the predilection of peptic ulcer to occur near the junction of different types of epithelium. Johnson has suggested that gastric ulcers having the secretory pattern of duodenal ulcer should have surgery designed for the latter.

More patients having intractable ulcer have poor results from surgery than those operated for other indications. This is more easily correlated with environmental and personality factors than with pathological and laboratory differences. These personality factors have been defined, and are useful in the pre-operative estimation of end results.

Olansky, Sidney, M.D.; McCormick, Glen E., M.D., with Technical Assistance of Mrs. Pat Achord, Emory University Clinic, Atlanta 22, Georgia, "Further Laboratory Studies on the Sezary Syndrome," South. M.J. 56:824-827 (August) 1963.

A case is presented of the Sezary Syndrome in which the outstanding clinical signs were a striking erythema and painfully fissured and hyperkeratotic palms and soles presenting in a well developed and otherwise healthy appearing patient.

In regard to treatment, the patient showed no response to Aminopterin, consistent response to moderate amounts of betamethasone and at least partial improvement with methotrexate. The unusual mononuclear cell with its peripheral rosette of PAS positive diastase-resistant vacuoles associated with this disease was consistently demonstrated in the peripheral blood, bone marrow, dermal infiltrate and on a lymph node imprint.

Moore, M. Brittain, Jr., M.D., 1600 Clifton Road, N.E., Atlanta 22, Georgia; Freeman, Robert G., M.D.; and Knox, John M., M.D., Houston, Texas, "Granuloma Inguinale," South. M.J. 56:860-863 (August) 1963.

An elderly Negro woman with extensive pelvic granuloma inguinale clinically suggestive of carcinoma of the cervix (Stage IV) is described. Despite appropriate antibiotic and supportive therapy, urinary obstruction progressed, intractable cardiac failure developed and the patient died. Tissue biopsy and other laboratory findings are reported and finally autopsy findings described. With antibiotics presently available as well as improved supportive therapy, dissemination of granuloma inguinale should be successfully prevented or controlled in virtually all instances.

H. H. Turner, M.D., Oklahoma City; Greenblatt, R. B., M.D., and Dominguez, H., M.D., Medical College of Georgia, Augusta, Georgia, "Syndrome of Gonada Dysgenesis and Abdominal Testis with an XO/XY Chromosome Mosaicism," Clin. Endocrinol. & Met. 23:709-716 (July) 1963.

A link between certain types of gonadal dysgenesis and male pseudohermaphroditism was furnished by a study of

two phenotypic female patients with asymmetric gonadal differentiation. In each case, at laparotomy a unilateral testis and a contralateral rudimentary gonadal streak were found, along with a uterus and fallopian tubes. Both of these had chromatin-negative buccal smears, and on leukocyte culture the chromosome analysis revealed an XO/XY mosaicism in each. Abnormal development of the external genitalia was present, in that the vaginal orifice in each was unusually reduced in size and the clitoris was considerably enlarged. One of the patients had the appearance of a classic Turner's syndrome, but with androgenic manifestations. The other patient was an atypical Turner's syndrome. Although there was no webbing of the neck, the neck was shorter than that normally seen, and the hair line was somewhat lower on the back of the neck. The carrying angle was slightly increased. The patient was of diminished stature with ambiguous development of the external genitalia.

Steinhaus, John E., M.D., Ph.D., and Gaskin, Lewis, M.D., 36 Butler Street, Atlanta 3, Georgia, "A Study of Intravenous Lidocaine as a Suppressant of Cough Reflex," Anesthesiol. 24:285-290 (May-June) 1963.

A comparison of lidocaine and meperidine as depressants of the cough reflex during general anesthesia revealed that the local anesthetic could completely suppress cough without severe respiratory depression whereas the opiate caused respiratory arrest in a high percentage of patients before this reflex was depressed. In a study which added the irritant effects of diethyl ether to the endotracheal tube during induction of lidocaine resulted in significantly shorter and smoother inductions when compared to a saline placebo. These studies indicate that the local anesthetics are representatives of a qualitatively different type of central nervous depression which may offer a practical therapeutic approach to the control of the cough reflex and related reflexes of the upper respiratory tract.

Boling, Edgar, M.D., and Finch, Henry, M.D., 490 Peachtree Street, N.E., Atlanta 8, Georgia, "Villous Tumors of the Colon and Rectum," Am. Surgeon 29:413-417 (June) 1963.

The authors first discussed the question, "what is a villous tumor?" This included the rare villous papilloma and the common adenomas with papillary arrangement of their luminal poles. The papillary adenoma and the papillary adenocarcinoma are frequently included under the terms villous tumors. A description of the gross findings, as well as the microscopic picture, is described. The characteristic clinical findings of the villous tumor—soft consistency, no induration, no ulceration, no fixation—are emphasized.

Then the question, "how are villous tumors to be treated?" was approached. Twenty-one cases were reported. A more conservative treatment is recommended for this type of carcinoma, either local excision or a less radical resection.



DEATHS

W. F. REAVIS, a former President of the Medical Association of Georgia and a former Waycross urologist, died August 16, 1963, at Emory Hospital, Atlanta, following a short illness. He was 73 years old.

Dr. Reavis, following his retirement from practice in Waycross in 1959, made his home in Mount Dora, Florida.

He had practiced in Waycross for 40 years and at the time of his retirement was associated in practice with Dr. Lovick Pierce.

Dr. Reavis was a staff member of Memorial Hospital and the former Atlantic Coast Line Hospital. He was instrumental in the establishment of Memorial Hospital and the Ware County Hospital.

He served as president of the state medical association in 1952. He was also a former delegate to the House of Delegates of the Medical Association of Georgia and he was chairman of the Council of Delegates of the Medical Association of Georgia.

Dr. Reavis also served as president of the Eighth District Medical Association and the Ware County Medical Society.

He was a steward of the First Methodist Church, former president of the Okefenokee Golf Club, former president Waycross Rotary Club and former member of the Waycross Board of Education.

An ardent sportsman, he was a member of the Dover Bluff Club, and as a camellia enthusiast he was noted for his rare specimens of blooms.

Survivors include his wife; one son, W. F. Reavis, Jr., Augusta; three daughters, Mrs. Ed Roe Stamps, Macon; Mrs. Sid Willingham, and Mrs. Mark Cooper, both of Rome.

LUCIUS A. BAILEY, 62, Director of Unit 3, Milledgeville State Hospital, died August 11, 1963, in a local hospital.

Dr. Bailey, a native of Ellenton, S. C., attended the University of Georgia and received the M.D. degree from the Medical College of Georgia. His internship was at University Hospital in Augusta, and at Bellevue Hospital, New York City.

The physician came to Milledgeville in 1930 as Baldwin County Health director. He joined the staff of Milledgeville State Hospital in 1931.

In 1940 he resigned to enter private practice in Milledgeville. He was Chief of the medical staff at Scott Hospital for a number of years, and in 1956 returned to the State Hospital staff.

Dr. Bailey is survived by Mrs. Bailey and one daughter, Mary Elizabeth Bailey.

EVERETT L. BISHOP, Atlanta pathologist, died August 12, 1963, at his office in the Medical Arts Building after a heart attack. Dr. Bishop was a native of Savannah and had lived in the Atlanta area since

1925. He received his medical degree from the University of Maryland and did postgraduate work at Cornell University.

He was a founding fellow of the American College of Pathology, a past president of the International Academy of Pathology and a founder and past president of the Georgia Association of Pathologists.

For the past several years Dr. Bishop had served as a consultant at Emory University, Piedmont, Grady Memorial, Atlanta VA and Lawson VA hospitals. He was a member of the American Cancer Society and had served as a director of the Georgia Division of the society.

He was a veteran of both world wars and served as a commander in the Navy Medical Corps during World War II. He was a member of the American Medical Association, the Fulton County Medical Society, and the Presbyterian Church and was a Mason.

Dr. Bishop is survived by his wife, the former Gladys Young; a daughter, Mrs. C. Barry Henderson of Tokyo, and two sons, Dr. E. L. Bishop, Jr., of Tuscaloosa, Alabama, and William F. Bishop of Atlanta.

POLK SANDERS LAND, 48, Muscogee County physician died August 7, 1963, at The Medical Center, Columbus, following a long illness.

Dr. Land graduated from the Medical College of Georgia and served his internship and residency at University Hospital, Augusta. He was a member of the staffs of Columbia City and Cobb Memorial Hospitals, and was a member of the Muscogee County Medical Society.

Dr. Land had served as Muscogee County physician since March 6, 1962, having been appointed by the Muscogee County Commission to replace the late Dr. F. L. Cosby.

Survivors include his wife, Mrs. Margaret Mulherin Land, Columbus; three daughters, Margaret, Elizabeth, and Katherine Land, all of Columbus, and four sons, Stephen, Frank, Michael and Christopher, all of Columbus.

THOMAS V. MATTHEWS, Atlanta, was found dead in his apartment August 23, 1963.

Dr. Matthews, a lifelong resident of Atlanta, graduated from old Boys High School and Emory University. He received his medical degree from the Harvard Medical School, and interned at Massachusetts General Hospital in Boston.

He was a member of the Fulton County, Georgia and the American medical associations. He was a member of the Second Ponce de Leon Baptist Church.

Survivors include a daughter, Miss Leedell Matthews; and a son, Thomas V. Matthews, Jr., both of Atlanta, and two sisters, Mrs. Charles K. Howard, Atlanta, and Mrs. Marvin R. Smith, Cordele.

RICHARDO MESTRE, 74-year-old retired Atlanta physician, died in a private hospital August 5, 1963.

A native of Puerto Rico, Dr. Mestre had lived in Atlanta about 34 years. He received his BS and MD degrees from the University of Maryland.

A veteran of both world wars, he was graduated with the first class of flight surgeons at Mitchell Field, Long Island, in 1923. He worked with the Veterans Administration 33 years, retiring in 1952. From 1953 until 1960 he was associated with Lockheed Aircraft Corporation.

He was a member of the Cathedral of Christ the King, the American Medical Association, the Medical Association of Georgia, the Fulton County Medical Society, the VFW and the American Legion.

Dr. Mestre is survived by a son, Lt. Ricardo W. Mestre, USAF, Mountain Home, Idaho, and a sister, Mrs. Angel A. Sanz, Puerto Rico.

SOCIETIES

TENTH DISTRICT MEDICAL SOCIETY met August 22 in Washington, Georgia, and elected new officers. Serving as President will be Henry Althisar, M.D., Thomson; as Vice-president H. A. Thornton, M.D., of Greensboro; and Julius Johnson, M.D., Augusta will serve as Secretary-Treasurer.

The program, which centered around the use of facilities at Talmadge Memorial Hospital, Augusta, was headed by Herbert Alden, M.D., Atlanta. The two other featured speakers were Rufus Payne, M.D., Brunswick, and Harry O'Rear, M.D., of Augusta.

PERSONALS

First District

JOHN H. ANGELL of Savannah recently began a part-time office practice in the field of obstetrics and gynecology in Springfield. Dr. Angell, who is a partner of DARNELL L. BRAWNER, will hold office hours each second and fourth Wednesday afternoons from 2 to 4 p.m. in the offices of RAY D. WEBB.

Second District

No News Submitted.

Third District

Columbus orthopedic surgeon, J. C. SERRATO, a native of Monterrey, Mexico, is currently heading a project called The Inter-American Council for Medical Assistance, Education and Research, Inc. with headquarters in Columbus. The non-profit organization is a clearing house for medical equipment, literature, and medications and funds earmarked for humanitarian groups in Latin America. One of its undertakings at present is the establishment of a medical college at one of the major private universities in Mexico City. Dr. Serrato serves as Chairman of the Council with assistance from several Columbus businessmen. Trustees include ARTHUR BERRY, Columbus, and BEN H. JENKINS of Newnan.

Columbus surgeon, A. B. CONGER, was guest speaker August 6, at the Muscogee County Chapter of Medical Assistants Association meeting held in the Health Department auditorium in Columbus. Dr. Conger's topic was the physical fitness of the modern woman.

Fourth District

No News Submitted.

Fifth District

Several Georgia doctors attended and participated in the 16th Annual Postgraduate Obstetric-Pediatric Seminar held August 22-24, at Daytona Beach, Florida. B. R. GENDEL, Professor of Medicine at Emory University School of Medicine, Atlanta, and FREDERICK P. ZUSPAN, Augusta, Professor and Chairman of the Department of Obstetrics and Gynecology at the Medical College of Georgia were included on the seminar faculty, and HELEN BELLHOUSE, Director of the Maternal and Child Health Service, Department of Public Health, Atlanta, moderated the second of the three day sessions.

CHARLES E. STONE, JR., Atlanta, Division Chairman of this fall's United Appeal Campaign, has appointed S. ANGIER WILLS, Decatur, as District Chairman for the Campaign. Dr. Wills is responsible for solicitations from Decatur doctors in the drive which began October 1.

J. D. MARTIN, JR., Atlanta, at the invitation of the James IV Association of Surgeons, spent the last of August and the first few weeks of September as a visiting professor to medical schools in South Africa. The Association is a group of English-speaking surgeons who foster and support two such visits each year to surgical centers in English-speaking countries. One of these tours is named in honor of the late DANIEL COLLIER ELKIN, for many years the Joseph B. Whitehead Professor of Surgery in Emory's School of Medicine. The purpose of the tour is to exchange ideas about the practice and teaching of surgery.

Atlantan, NAPIER BURSON, has recently been named Chairman of the Hospital and Health Division of the Community Council of the Atlanta Area, Inc. The Community Council of the Atlanta Area, Inc. is the agency charged with coordination, research and planning for health and welfare in the five county area. It is supported by the United Appeal and local foundations.

Sixth District

WILLIAM A. WILLIAMS, JR. has announced the opening of his office for the general practice of medicine in the Riverside Center, Macon.

Also opening an office in Macon is A. M. PHILLIPS, JR., who will practice orthopedic surgery. His offices are located in the Doctors Building in Macon.

FRANK M. CRONIC recently became associated with W. H. SOMERS and E. H. STANLEY in the practice of radiology at Macon Hospital.

Seventh District

RICHARD C. MANUS, Austell, has joined the staff at the Austell Hospital. He will be associated with J. G. BUSSEY and CHARLES REY in the practice of medicine and surgery.

Joining H. D. MEADERS and E. J. REILLY, Marietta, in the practice of gynecology and obstetrics is EVANS E. NICHOLS, a graduate of the Medical College of Georgia.

Eighth District

Returning from the army, OLLIE McGAHEE, JR., opened his office August 12, in Jesup for the practice of medicine and surgery.

THE ASSOCIATION / Continued

Chosen in July as staff officers for Duncan Memorial Hospital, Hazlehurst, were C. R. YOUNG, President; BEN GOLDMAN, Vice-President; and DAN ELROD, Secretary-Treasurer.

Ninth District

No News Submitted.

Tenth District

EUGENE C. CRISLER of Augusta has been ap-

MAG SUB-COMMITTEE ON MENTAL HEALTH MEETING

THE MEETING OF THE Sub-Committee on Mental Health of the Medical Association of Georgia was called to order by Chairman James N. Brawner of Atlanta at 11:05 a.m. on August 25, 1963, in the Powell Building of Milledgeville State Hospital, Milledgeville, Georgia.

In attendance at this meeting as Committee members were: E. E. Davis, Thomasville, Second District; Frank A. Wilson, Leslie, Third District; Herbert D. Tyler, Thomaston, Fourth District; James N. Brawner, Atlanta, Chairman, Fifth District; J. R. S. Mays, Macon, Sixth District; Leo Smith, Waycross, Eighth District; and W. D. Stribling, Gainesville, Ninth District. Dr. Addison M. Duval, Director, State Dept. of Public Health, Division of Mental Health, Atlanta, Georgia, was also in attendance as an Ex-Officio member of the MAG Committee. Also attending the meeting was Mrs. J. G. Bohorfoush, Milledgeville; Dr. I. H. MacKinnon, Superintendent, Milledgeville State Hospital, and Mr. M. D. Krueger, Atlanta, MAG Headquarters Office Staff.

The minutes of the Sub-Committee on Mental Health of April 21, 1963, were approved on motion duly made and seconded.

Chairman Brawner then called for a report district-by-district on Mental Health activities over the state. For the Second District, Dr. Davis raised the question on intensive treatment in his area. He also reported on community planning in Thomasville and Albany. For the Third District, Dr. Wilson reported on the Columbus activity and the NIMH training program for that county as operated by the Bradley Clinic of Columbus. He reported on their activity in Sumter County and Troup County. For the Fourth District, Dr. Tyler reported on Upson County activity in connection with the Bradley Clinic program. Dr. Tyler mentioned the child guidance health meetings and that Troup County was also active in the Bradley Clinic training program. For the Fifth District, Dr. Brawner discussed the activity of a planning committee for the Atlanta Area Planning Council. Outpatient care was emphasized and more inpatient service necessary with state coordination. Dr. Brawner also reported on the activity in DeKalb county. For the Sixth District, Dr. Mays reported on the activity at Milledgeville and Macon and the need for proposed activity in the Dublin area. He also spoke of progress on the program of religion and medicine in Macon and discussed the National Academy of Mental Health and Religion. There was discussion on working out some system of having a psychiatrist on call for the emergency room of the hospital in those areas that had psychiatrists. For the Eighth District, Dr. Smith reported that the county society presidents within his area had been asked to appoint Mental Health Committees. He related that Brunswick and Waycross share the services of a psychiatrist and that beds are reserved for psychiatric patients in the Waycross Memorial Hospital. For the Ninth District, Dr. Stribling reported that he had asked all counties to have a Mental Health Committee and had had a good response. He stated that Gainesville is establishing a Child Guidance Clinic and that they plan to have psychiatric beds at the Hall County Hospital. He stated further that outpatient psychiatric service was being planned.

Department of Public Health Activity

Dr. Duval then gave a report on progress of activities in the Division of Mental Health, State Department of Public Health. He spoke of the progress and problems at the Milledgeville State Hospital, Gracewood, and the proposed Atlanta Institution. He

pointed to the consulting medical staff of Memorial Hospital of Washington County. The appointment of Dr. Crisler is in addition to the two other radiologists on the staff, STUART H. PRATHER and JAMES D. GRANT.

PAUL R. BROWN of Augusta is the recipient of a Southern Medical Association Residency Training Grant. The 1963-64 recipients were announced in August by the SMA. Dr. Brown is one of four Southerners receiving a grant.

discussed rehabilitation services and the alcoholism program. He emphasized county level alcoholism programs and community mental health programs. He spoke of the need for in-service and postgraduate mental health education services and stated that long range statewide mental health programs were being planned with emphasis on comprehensive health centers on a regional basis. Dr. Duval stated that this planning would be on a two year basis and that the blueprint from the plan would be invaluable in the state of Georgia.

State Auxiliary Activity

Mrs. Bohorfoush reported on the activity of county auxiliary medical societies and the state auxiliary medical society. Some items she discussed were items on suicide, personal services, the history of mental health in Georgia, a mental health directory and educational activities. Upon her request she was advised that the use of an HEW pamphlet entitled "Some Facts About Suicide" would be approved if it was distributed through proper health agencies. She also discussed another state workshop on mental health for Auxiliary members at such time as would be advisable. The Sub-Committee agreed to assist.

The Yochem Report

Chairman Brawner stated that the original Yochem report of some seven recommendations had been referred back to the Sub-Committee on Mental Health for further clarification and recommendation to the Council of the Medical Association of Georgia. He reported that items 1, 2, 3, 4, 5 and 7 of the original Yochem report had already been implemented and that he would like to direct the Committee's attention to item six and the six sub-items.

Item 6(a) Dr. Brawner reported that this recommendation to establish, where appropriate, psychiatric units in general hospitals and community health centers seemed underway and general discussion ensued. Item 6(b) which recommended the sponsoring of formal and informal communication on mental health knowledge among specialists and general practitioners was discussed and it was thought that this should be implemented further, but that it was already in progress. Item 6(c) which recommended the fostering of collaborative in-service programs of all levels, was also discussed and it was agreed that this project is underway. Item 6(d) which recommended the creation of action groups for liaison with local legislators for sustaining progress and mental health facilities, was explained and it was recommended that the Mental Health Committee work with the Association Legislative Committee on such matters to implement any specific recommendation in the field of legislation. Item 6(e) which proposed the encouragement of physicians to take group action to correct the deficiencies in mental health facilities was discussed and it was recommended that ways and means continually be sought to attain this goal. Item 6(f) which proposed the elimination of legal impediment to the provisions of humane and scientific medical treatment of the mentally ill, was emphasized.

It was proposed and approved that a mental health page in the *Journal of the Medical Association of Georgia* be devoted to the subject of Voluntary Admissions and Dr. MacKinnon stated that Dr. James Craig could prepare such an article for Dr. Brawner and that Dr. Brawner discuss with Dr. Edgar Woody, Editor of the *Journal*, the possibility of also devoting the cover of the *Journal* to this subject to highlight and draw attention to the Mental Health page on Voluntary Admissions.

On motion duly made and seconded it was voted, that since the Council of the Medical Association of Georgia has agreed to an enlarged rotating Sub-Committee on Mental Health and suggested that the Committee members themselves decide how

this should best be accomplished, that the following procedure be submitted to Council for approval:

"Each year at least three new members, one of whom is a Past President of the Georgia Psychiatric Association, be appointed to serve for three years, with a Past President of the G.P.A., to serve one year as Chairman; and, the present Committee, by the end of the current year, shall determine the term of service for each member for one, two or three years respectively."

On motion duly made and seconded it was voted to recommend to Council that as a means of enhancing state level communicating and mutual understanding between the MAG and the State Health Department that Dr. John Venable and Dr. Addison Duval be invited to be guests (without vote or official capacity) at the regular meetings of Council.

On motion duly made and seconded it was voted to recommend to the Council of the Medical Association of Georgia that the Council endorse and support the recommendations made to Mr. James Bentley, Comptroller General and Insurance Commissioner of Georgia, by the Mental Illness Insurance Study Committee. These recommendations are attached herein as a part of these minutes. It was further voted and approved that these recommendations, if so approved by MAG, be publicized by MAG to all physicians and to the State Chamber and State Junior Chamber of Commerce in order to encourage physicians, other individuals and business concerns to review their health insurance policies and specifically to inquire of and insist on the coverage of mental illness on an equal basis to that for any other illness. It was brought up that an increase in public demand will enhance the early provision of broader insurance coverage for mental illness and in turn greater opportunities for private care and less burden and responsibility on our overloaded state facilities.

On motion duly made and seconded it was voted that the

Committee recommend to the Council of the Medical Association of Georgia activating "utilization committees" per the suggestion that physicians and hospitals should participate through MAG, the Georgia Hospital Association and the insurance carriers through their state health insurance organizations.

Hypnosis Problem

Mr. Krueger asked for the recommendations of the Mental Health Sub-Committee on possible proposed legislation to control the use of hypnosis. By general agreement it is recommended that a law restricting the use of hypnosis be drafted and sent to Mental Health Sub-Committee Chairman, Dr. Brawner, who would advise on the matter before such proposal is presented to Council. It was emphasized that the use of hypnosis in health care treatment should be restricted to doctors of medicine, dentists, and those properly trained clinical psychologists working under the supervision of a doctor of medicine.

AMA Query

On motion duly made and seconded it was voted to recommend to the AMA Department of Mental Health that their proposed newsletter be activated and further that also a proposed mental health law bulletin be initiated to keep mental health committees and other interested parties abreast and to provide a means of communication on matters in the mental health field.

The Sub-Committee expressed its appreciation to Dr. MacKinnon for the delicious luncheon he provided and for the privilege of meeting at the State Hospital.

There being no further business, the meeting was adjourned at 3:15 p.m. and by general agreement it was recommended that the next meeting be held in Macon, Georgia, at the discretion of the Chairman.

AMA STRESSES EMERGENCY MEDICAL IDENTIFICATION SYMBOL

This is the universal emergency medical identification symbol devised by the AMA. The person who displays it carries upon his person information which should be known to anyone helping him during an accident or sudden illness. The symbol means: "Look for medical information that can protect life."

The American Medical Association designed this symbol to be a universal sign, recognized by all who might perform first aid, indicating the presence of information important to the life and death of the wearer. It is offered to all who make or distribute identification cards or medical emergency signal devices.

Who Should Carry Emergency Medical Identification?

Who should carry identification? Everyone! Every person should have a card, such as the AMA emergency medical identification card, to show who they are, where they live, whom to call if they become ill or injured, the name of their doctor, and when they were immunized, particularly against tetanus or lockjaw. People with special health problems should also wear an alerting device — a wristlet, anklet or dog tag indicating their need for medical care.

The AMA Emergency Medical Identification Card

On the emergency medical identification card should be noted any special problems that need immediate attention in an emergency or could cause an emergency. For example, diabetics must be identified so that needed doses of insulin can be given. A notation of diabetes also protects one in insulin shock or diabetic coma from being mistaken for a drunk.



Some people's problems are so serious that it is absolutely essential for the first aider to know about them in an emergency. Such people should wear a durable signal device made of metal or plastic on a chain about their neck or on their wrist or ankle. These are worn all of the time—in bed, in one's bath, while swimming, on the job—to be sure the right information gets to the first aider or receiving physician if the victim is, by chance, unconscious or unable to communicate.

The signal device should carry as minimum information the emergency medical identification symbol on one side and on the other, in one or two words each, the most important information for those who might come to your aid in an emergency. It is also helpful to record the names and phone numbers (including area code) of your nearest of kin, another relative or close friend, or your personal physician.

Where To Obtain Cards and Devices

Identification cards are distributed by many national as well as local health agencies. The American Medical Association distributes one. Single copies are free on request. Quantities can be purchased from the AMA at \$1.00 per hundred, \$5.00 per thousand.

For further information write to: Department of Community Health and Health Education, AMA, 535 N. Dearborn St., Chicago 10, Illinois.

17th CLINICAL MEETING

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Contents

Scientific Articles

FETAL DISTRESS
Paul Underwood, M.D.; Lawrence L. Hester, Jr., M.D., and Joseph H. Cutchin, Jr., M.D. 461

RADIOISOTOPE ORGAN SCANNING
Menard Ihnen, M.D. 465

RENOVASCULAR HYPERTENSION
Milton F. Bryant, M.D. 468

PREANESTHETIC EVALUATION OF BLOOD LOSS IN THE TRAUMATIZED PATIENT
Kenneth K. Keown, M.D., and Robert N. Miller, M.D. 473

Editorials

SHOCK AND VASOPRESSOR AGENTS 477

THE BARNSTORMER 478

GRIEF 479

Features

President's Letter 481

Cancer Page 482

Heart Page 484

Legal Page 486

Mental Health Page 487

Current Clinical Concepts 489

Physician's Bookshelf 492

The Association

Deaths 494

Societies 494

Personals 495

MAG Constitution and Bylaws Board Meeting, September 19 495

MAG Executive Committee of Council Meeting, August 15 497

Advertising Index 54A

Calendar 475

Cover

Election year '64 is just around the corner. The political pamphlets on the cover are a "vest pocket" edition of "The Barnstormer" and are available through GaMPAC. Design by John Stuart McKenzie, Atlanta.

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FETAL DISTRESS

Paul Underwood, M.D.; Lawrence L. Hester, Jr., M.D., and
Joseph H. Cutchin, Jr., M.D.,* *Charleston, South Carolina*

■ *New techniques for evaluating the status of the unborn infant are described.*

ALTHOUGH MUCH has been written about fetal distress, its definition is still vague and under much discussion. It is most frequently associated with bradycardia and meconium stained amniotic fluid during labor. These supposed signs of fetal distress are present in from three to ten per cent of all deliveries depending upon the visual acuity for color of the observers.^{1,2} The definition of fetal distress should not only cover the period of time near or during labor but include the entire intrauterine life of the fetus. This distress prior to the onset of labor is the most difficult to diagnose and manage. Many times during labor the etiology of fetal distress is obvious and the treatment routine for the individual obstetrical unit. But when does intrauterine distress occur in the expectant mother with diabetes, erythroblastosis fetalis, pre-eclampsia, or hypertensive vascular disease?

Available Guides

Many clinical and laboratory observations such as decreased fetal activity, maternal antibody titres, and radiological evidence of fetal edema—the halo sign, are already available to guide the obstetrician. However, a more precise test is needed to determine the point at which the fetus would be under less jeopardy if delivered. Emphasis is being placed on placental function.

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Presented at the 109th Annual Session of the Medical Association of Georgia, May 7, 1963, Jekyll Island, Georgia.

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Hellman³ administered intravenously one mgm. of Atropine Sulfate to the mother and produced blockage of the vagus nerve in the fetus although there was a long time delay. He also observed that in some severely pre-eclamptic mothers, no fetal atropine effect was produced. Thus, if an end point and time delay could be found where no vagal blockage occurred in the fetus with moderate or severely depressed placental function, a relatively simple test for assessment of placental function and individually the future well-being of the fetus would be achieved.

Maternal Hypoxia

At the Medical College of South Carolina, placental function was studied through maternal hypoxia which was produced by inhalation of ten per cent oxygen and 90 per cent nitrogen. The fetal heart rate was used as the indicator of the placenta's ability to transfer oxygen. The response of 40 patients was observed—12 normals, 13 pre-eclamptics, six third trimester bleeders, four with hypertensive vascular disease, and five with miscellaneous complications. Our findings indicate that the normal placenta can maintain adequate fetal oxygenization as represented by no change in the fetal heart rate for over seven minutes with this severe hypoxia. The average maternal brachial artery oxygen saturation was 73 per cent. The 28 complicated cases showed a decrease of over 20 beats per minute in the fetal heart rate in less than seven minutes. One severe pre-eclamptic had a decrease of 50 beats per minute within 30 seconds. In eight cases bradycardia was preceded by

tachycardia; however, in only three cases did a tachycardia follow the bradycardia. No maternal or fetal complications resulted from these studies as far as we know. The fetal heart rate returned to the original base line level within minutes simply by allowing the patient to breath room air. Further study is being done and it is hoped that through a large series of cases a figure may be determined indicating fetal distress.

Transfer of Substances

Placental function may be measured by a transfer of labeled substances. Flexner⁴ used radio-active sodium to measure placenta transfer throughout pregnancy in normal patients and occasionally patients with toxemia. There was a progressive increase in the transfer of radio-active sodium across the placenta from the ninth to the 36th week of gestation. This increase in the apparent permeability of the human placenta was approximately 70 times. There was also a decrease in placenta transfer from the 36th week of gestation to term. The type of anesthesia was without effect on the transfer of radio-active sodium. One of two patients with pre-eclampsia showed a marked decrease in placenta transfer.

Green and Touchstone⁵ attempted to evaluate placenta function by urinary estriol determinations. The idea being that during pregnancy almost all estrogen was derived from the placenta of which ninety per cent was in the form of sodium estriol glucosiduronate. A study of 279 pregnancies revealed that normal values rarely fell below 12 mgm. per 24 hours and never below seven mgm. per 24 hours. With fetal deaths values below one mgm. per 24 hours were found. In instances where fetal death occurred while determinations were being run, values below four mgm. per 24 hours were found. This was true in patients with diabetes mellitus, pre-eclampsia, hypertension, and postdate pregnancies. These findings were not of value in erythroblastosis fetalis since the defect lies in the fetal hematopoietic system rather than placental function.

State of Health

It would be of value to accurately access placental function, but even more valuable would be the ability to determine the state of intrauterine fetal health. The latter is more difficult to determine than the former since it is even difficult to access the extra-uterine health of an individual. Placental function or dysfunction should not be too difficult a problem to solve once our investigative forces are marshalled. The placenta has been in obscurity too long, and is

only now being recognized as an organ of great value for investigative purposes.

If placental function could be diagnosed accurately, then a decision to terminate the pregnancy could be made based on a scientific fact. However, the decision to induce labor, or to terminate pregnancy by cesarean section, is founded today on nebulous theories, inaccurate observations, and the influences of a few personal cases. The personal cases influence our judgment tremendously since they can be recalled easily years later, yet statistically they are of no significance. Placental function determinations could tell us when to terminate pregnancy in pregnant patients having diabetes mellitus, hypertensive vascular disease with or without superimposed pre-eclampsia, pre-eclampsia, postdate pregnancy, postmaturity (placenta dysfunction), and chronic nephritis.

Fetal Heart Rate

Next we turn our attention to the diagnosis of fetal distress in labor. Fetal distress is thought to be present if the fetal heart rate is more than 180 per minute or less than 100 per minute throughout the interval between contractions and/or meconium is present with a vertex presentation.

Tachycardia may on infrequent occasions be observed as an indication of fetal distress; however, most often it is associated with maternal pyrexia. It is usually thought to be an early sign of anoxia⁶ and is present often in prolonged labors. With amnionitis and endometritis it indicates fetal infection. With extra-uterine infection such as infectious hepatitis and pyelonephritis, it indicates possibly a toxic effect upon the fetus. Tachycardia of three hundred beats per minute has been observed by us and recorded on a phonocardiogram several hours prior to death.

Fetal bradycardia may be due to pressure on the advancing fetal head or fetal hypoxia. The fetal hypoxia may be due to cord strangulation, abruptio placenta, placenta previa, pitocin stimulation of the uterus with a sustained contraction, or placental dysfunction. Sciarra⁷ studied 422 cases with documented fetal bradycardia and found 78 per cent of the bradycardia occurred during the second stage of labor and 22 per cent occurred in the first stage. In those occurring in the first stage of labor 43 per cent were due to obvious obstetric complications. The remaining patients had unexplained fetal bradycardia and were managed either by cesarean section or by observation and vaginal delivery. Most sections were done when the cervix was less than six cm. dilated. In only 39 per cent of the cases of fetal bradycardia in the first stage could a probable cause be determined. In most cases the cause was asso-

TABLE I

Number Deliveries	1199
Number Fetal Distress	56
Incidence	4.7%

ciated with an unrecognized umbilical cord complication. Ebner⁸ found the occurrence of fetal bradycardia related to the extent and duration of maternal hypotension. He noted that fetal bradycardia occurred only when the maternal hypotension had a total duration greater than four minutes, and thereafter the incidence of bradycardia appeared to be proportional to the duration of hypotension.

Meconium Observed

The meconium staining of amniotic fluid was first observed by Schwartz⁹. He reported, more than 100 years ago, the clinical situations under which meconium was passed. He stated: "That the presence of meconium is always proof of suppression or reduction of respiratory placental communication and is a reliable sign of death to the fetus or of an endangering of life in the act of birth." It has been thought by many to suggest a sign of interference with the trans-placental transfer of oxygen. Windle states that the newborn monkey intact in its gestation sac will pass meconium during a period of oxygen deprivation.⁶ In the lamb and in the human adult active bowel movements are seen only in the terminal stage of anoxia from which recovery is rare. Walker⁶ states that at this stage in our knowledge we have very little certain information as to the mechanism of meconium being passed or why a fetus can empty the whole of its large bowel contents steadily into the amniotic sac. It appears from his studies that meconium stained amniotic fluid is associated with a deficiency of oxygen mainly differentiated from other types by a very low reading in the blood of both umbilical vessels (except as noted following slowing of the fetal heart). With meconium stained amniotic fluid alone Walker⁶ noticed an 8.8 per cent incidence of fetal distress, whereas only 7.3 per cent was noted with meconium plus fetal bradycardia. In contrast to many studies with fetal bradycardia alone he found only a 1.9 per cent incidence.

At the Medical College of South Carolina there were 1199 deliveries between October 1, 1962, and March 31, 1963. Fifty-six infants for an incidence of 4.7 per cent developed fetal distress manifested by either meconium stained amniotic fluid associated

TABLE II
WAYS FETAL DISTRESS PRESENTED

	Lived	Died
Meconium Stained	28	3
Bradycardia	6	3
Meconium and Bradycardia	10	6
Total	44	12

TABLE III
INCIDENCE OF DEATH

	Total	Died	Per cent
Meconium	31	3	9.7
Bradycardia	9	3	33.3
Meconium and Bradycardia	16	6	37.5
Total	56	12	21.4

with a vertex presentation or a fetal heart rate under 100 (Table I). Meconium stained amniotic fluid was the most common type of fetal distress in the infants that lived; however, meconium stained amniotic fluid plus bradycardia was more prevalent in the infants that died (Table II). Meconium stained amniotic fluid alone carried a death rate of 9.7 per cent, while with bradycardia alone the incidence jumped to 33.3 per cent. Bradycardia plus meconium stained amniotic fluid only slightly increased the per cent to 37.5. The overall death rate in our series was 21.4 per cent (Table III). Amnionitis secondary to prolonged rupture of the membranes and prolapse of the umbilical cord were the two leading causes of death with abruptio placenta and the

TABLE IV
CAUSES OF DEATH

Prolapsed Cord	3
Amnionitis	3
Abruptio Placenta	2
Second Twin	2
Prolonged Second Stage Labor	1
Premature Breech	1

second twin following (Table IV). Only two infants had bradycardia associated with uterine contractions. All six infants born alive that later died had apgar ratings under five.

Of the surviving infants 28 or 64 per cent had only meconium stained amniotic fluid as the indicator of fetal distress. Unknown causes, prolonged labors, and severe pre-eclampsia in that order were the most common predisposing factors (Table V). In the group with bradycardia alone the etiology of the distress was different in each case except the two which developed hypotension following saddle block anesthesia at delivery (Table VI). In both these cases the fetal heart rate returned to normal following restoration of the maternal blood pressure. Among the ten infants with meconium stained am-

TABLE V
SURVIVING INFANTS
MECONIUM STAINED ONLY

Unknown	11
Prolonged Labor	9
Severe Pre-Eclampsia	3
Ruptured Uterus	1
Abruptio Placenta	1
Cervical Stenosis 2° Cone	1
Cord 3X Around Neck	1
Anemia (Hb 6)	1
Total	28

TABLE VI
SURVIVING INFANTS
BRADYCARDIA ALONE

Saddle Block with Maternal Hypotension	2
Prolonged Second Stage Labor	1
Cord in True Knot	1
Cord About Neck	1
Unknown Cause	1

niotic fluid and bradycardia, four had small pelvises with prolonged hard labors. In three cases the cause was unknown (Table VII).

Table VIII reveals the mode of delivery in each group. Three of the 12 infants that died were delivered by cesarean section—two prolapsed cords, and one abruptio placenta. Also noteworthy was the 13 per cent incidence of mid-forceps deliveries. In all cases the mid-forceps were used as a result of the distress and the distress was not due to the mid-forceps.

This series was small and statistically of little significance; however, it does point out the importance of the signs of fetal distress.

Comment and Summary

Maternal mortality and morbidity has progressively decreased during the past years as a result of tremendous improvements in the fields of obstetrics, surgery, and anesthesiology, as well as the discovery of antibiotics. As a result, more attention is being focused upon the well being of the intrauterine fetus. Until this century the only feasible method of following the fetal condition was by its heart rate. Now through fetal phonocardiography, fetal electrocardiog-

TABLE VII
SURVIVING INFANTS
BRADYCARDIA AND MECONIUM

Small Pelvis with Long Hard Labor	4
Unknown Cause	3
True Knot in Cord	1
Circumvallate Placenta	1
Hypotension Following Spinal Anesthesia	1

TABLE VIII
MODE OF DELIVERY

	Living	Dead
Outlet Forceps or Spontaneous	35 (80%)	9 (75%)
Mid-Forceps	6 (13%)	0
C-Section	3 (7%)	3 (25%)

raphy, maternal hormone studies, and various placental function tests, the status of the unborn infant can be better evaluated. These techniques are still far from perfect. Fetal bradycardia and meconium stained amniotic fluid occur too often in the absence of any detectable pathology and with the delivery of a normal active fetus to be pathognomonic of true fetal distress. The management varies with the individual case. Obvious causes such as prolapse of the umbilical cord, severe pre-eclampsia, abruptio placenta, and dystocia guides one's course of therapy. The elderly primagravida or the sterility problem does have great influence upon the obstetrician.

The field of obstetrics which is most lacking is how to determine the exact point where placental function is inadequate. In other words, when is the infant of the severe pre-eclamptic or diabetic in less jeopardy delivered. Present experimental methods for determining this point have been discussed. At present the problem falls into the lap of the obstetrician for his particular beliefs as well as the peculiar circumstances of the individual patients.

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RECIPIENTS NAMED FOR W. B. SAUNDERS
WRITING FELLOWSHIP AWARD

The extensive and enthusiastic response to the announcement of the Saunders 75th Anniversary Writing Fellowship has resulted in the awarding of two grants instead of the previously announced single award. So many outstanding applications were received by the Selection Board from medical scientists of distinguished accomplishment, that an Executive Committee consisting of Robert F. Loeb, Rene J. Dubos, Henry Allen Moe, and Robert S. Morison recommended to the Saunders Company that it mark its anniversary with two equal fellowships, each in the amount of \$15,000.

Saunders accepted this recommendation and announces that the two recipients chosen by the eminent selection board are Dr. Herman M. Kalckar, of Harvard Medical School, and Dr. Paul B. Beeson, of Yale University School of Medicine. Dr. Kalckar will be writing on Biological Patterns of Cells in Developmental Defects and Disease States. Dr. Beeson will be writing on Associations of Specific Infections with Certain Disease States of Man. Formal presentation of the awards will be made individually to each grantee at two dinners to be held in the Fall and early Winter.

RADIOISOTOPE ORGAN SCANNING

Menard Ihnen, M.D., *Augusta*

- ***This new technique offers significant aid in the early diagnosis of many pathologic processes.***

RADIOISOTOPE SCANNING is a means of visualizing the size, shape, and internal structure of some organs such as liver, kidney, and thyroid. Further, it is possible to visualize lesions in some organs such as the brain if these lesions concentrate radioactive substances. Often, information gained by scanning could not be obtained by other diagnostic techniques; at other times, scanning supports or confirms diagnoses suggested by other diagnostic procedures.

Techniques

In almost all scan techniques, the patient is given a radioactive isotope orally or intravenously; after a period of time sufficient for distribution or concentration of the isotope, a scan is performed.

The apparatus used (Picker Magnascanner) consists of a scintillation crystal to detect the emitted gamma rays, a rate meter, a pulse height analyzer, a photoscanner attachment, and a dot scan attachment. The scan record is produced as the scintillation crystal moves horizontally over the patient at a constant rate, advancing at a constant interval and forming a series of parallel lines of activity.

The photoscanner attachment and the dot scan attachments are two independent records of the pattern of activity. With each record, the concentration of dots is proportional to activity. On the photoscanner, intensity of activity is also indicated by increasing blackness of dots. This additional dimension of the photoscanner makes interpretation much clearer and this has been responsible for much of the recent advance in this field.

There are a number of physical, physiological, and anatomical factors which limit the technique.

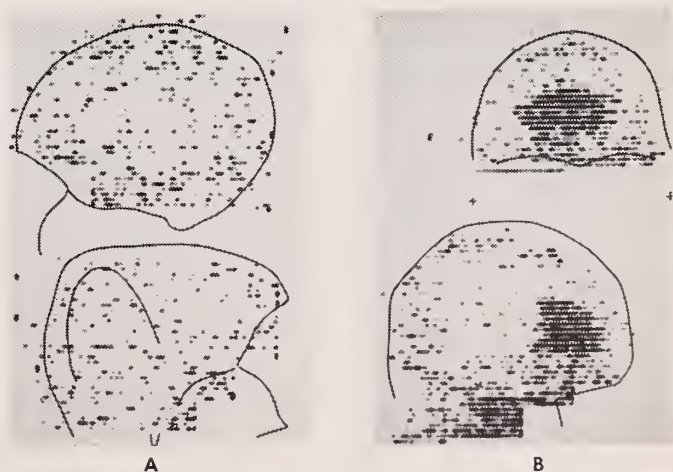
They are beyond the scope of this discussion. However, the sum of these factors is such that one does not expect to visualize defects in the liver which are less than two centimeters in diameter and one does not expect to visualize areas of increased uptake (lesions) in the brain which are less than two centimeters in diameter.

Additional details of technique for scanning particular organs are included in the following section.

Experiences in Organ Scanning

Brain: Brain scanning has been the most quickly accepted and the most useful scanning technique in our institution to date. The technique is essentially that used by Brinkman, et al,¹ utilizing Hg²⁰³ labeled Neohydrin (chlormerodrin). Mercurhydrin is given

FIGURE 1



A Normal brain scan one year after partial resection of glioblastoma followed by CO⁶⁰ radiation. No clinical evidence of disease.

B Positive brain scan. Heavy concentration on right lateral and frontal scans. Sixty year old man who had glioblastoma at surgical exploration.

ORGAN SCANNING / Ihnen

on the day before the scan to decrease radiation dosage to the kidneys. Scans are performed approximately six hours after the intravenous injection of the radioisotope. The actual technique of scanning is relatively simple. It is essential that the head of the patient remain in the same position during the period of scanning.

Areas of Activity

Lesions are seen as areas of increased activity. Scans are rather easily separated into three groups: scans showing no localized increase in activity are negative; those showing heavy uptake in well demarcated areas are positive; scans which show a definitely localized, slight increase over background are equivocal. To date, several patients with glioblastoma have had positive scans. A meningioma demonstrated less heavy uptake as did an astrocytoma of intermediate differentiation. Pinealoma, cerebral hemorrhage, a pituitary stalk tumor and other lesions not yet determined have shown equivocal scans.

Because of the lack of morbidity, scanning may be performed in poor risk patients who are not able to tolerate air studies or arteriography. Similarly, scanning is helpful in evaluating patients who do not have signs and symptoms which justify arteriography or air studies. Examinations may be repeated with minimal hazard to the patient.

A positive scan is direct evidence of a lesion in contrast to the indirect evidence of shift or displacement obtained from arteriography or air studies. The additional support of this direct evidence in establishing a diagnosis and the assistance of the scan in localization of lesions have been most helpful to neurosurgeons in our institution. After performing a modest number of these studies, it is clearly evident

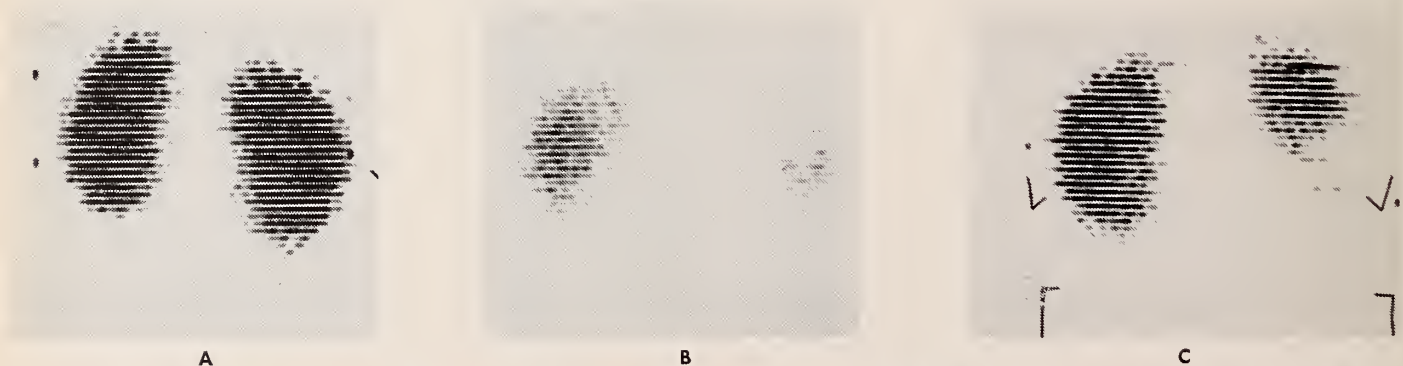
that close correlation between clinical and scan findings is imperative to derive the full benefit from scan information. Equivocal scan findings have added important support to other diagnostic studies in several cases.

Kidney: In contrast to brain scans, kidney scans using Hg^{203} Neohydrin (chlormerodrin) show lesions as defects in the dense background of the kidney. Approximately 100 microcuries of the radioactive material are injected intravenously and scans are performed with the patient in the prone position approximately one hour after injection. No morbidity has been encountered. The size and shape of the kidneys are usually easily evident from the scan outlines. The maximum count rate over the kidneys is a measure of the functioning kidney parenchyma. Riley, et al² emphasize estimation of functioning renal parenchyma by scanning and emphasize that this information may be quite helpful in attempts to salvage a portion of a kidney during a surgical procedure.

Demonstration of defects in the kidneys is equally important. Anything displacing or replacing renal tubular parenchyma would be expected to produce a defect. At the moment, there is no way to distinguish a carcinoma from a cyst. Scans may be helpful in demonstrating small, irregular defects representing pyelonephritis. The role of scans in screening patients for unilateral renal disease causing hypertension remains to be determined. Haynie, et al³ report that scans are more accurate than renograms, pyelography, or the Howard test in demonstrating renal vascular disease and are less accurate than aortagrams. In evaluating kidney scans one should remember the frequent small scars and cysts of the kidneys so commonly found at autopsy which are almost always clinically insignificant.

Liver: Using radioactive gold (Au^{198}) or I^{131} —labeled Rose Bengal, scanning produces a liver pat-

FIGURE 2

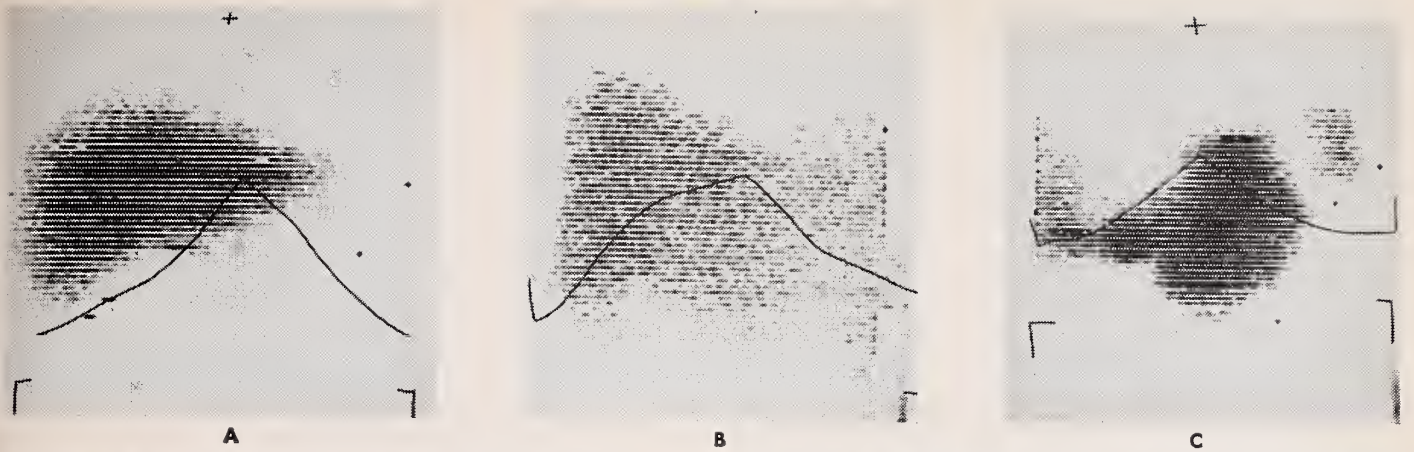


A Normal kidney scan. Hypertensive woman with no evidence of renal disease.

B Kidney scan with moderate decrease in uptake over left kidney and marked decrease in uptake over right kidney. 59-year-old woman with right staghorn calculus and no function by IVP; history of pyelonephritis.

C Scan showing defect in lower pole of right kidney. Elderly man with pathologic rib fracture due to metastatic adenocarcinoma. X-ray studies suggested carcinoma of right kidney and defect was shown by scan. At autopsy, renal lesion was a single cyst and primary site of carcinoma was pancreas.

FIGURE 3



- A** Normal liver scan. Chronic alcoholic with acute episode.
B Enlarged liver with diffuse reduction in uptake. Needle biopsy diagnosis: Cirrhosis. Clinical diagnosis: Cirrhosis.

- C** Defect in diaphragmatic aspect of liver consistent with metastatic carcinoma. Elderly woman with carcinoma of colon and epigastric mass. Epigastric mass is liver showing no defects.

tern usually quite satisfactory for determining size, shape and position.⁴ Radioactive gold has been more satisfactory in our experience. Scans are performed one hour after intravenous injection of a dose of 100 microcuries. Jaundice does not inhibit uptake of gold by the liver. Space occupying lesions produce defects in the dense background of the activity of the liver. Although one does not expect to demonstrate lesions less than two centimeters in diameter, this technique has great practical value in detection of liver metastases, abscesses, or cysts. Further, variations in the intensity of uptake are helpful in evaluating patients with suspected cirrhosis or hepatitis. Problems involving the size, shape, or internal structure of the liver are so common that one would expect liver scanning to be one of the most popular scanning techniques in the future.

Thyroid: The ability of the thyroid gland to concentrate iodine is a circumstance particularly favorable for good scanning. Scans are performed after an oral dose of approximately 50 microcuries of I^{131} . An opportunity to palpate the neck at the time of scanning, to compare palpable and functional outlines of the gland and to see concentrating ability of a palpable nodule is a most satisfactory way to examine the patient. Scanning proves helpful in evaluating thyroid nodules although it is not definitive.⁵ Scanning has been of considerable assistance to us in the evaluation of neck nodules developing after partial thyroidectomy for various reasons. Frequently, these nodules are remnants of thyroid tissue. Demonstration of vigorous uptake by scanning often permits conservative treatment.

Although radioisotope scanning is in an early phase of development, a number of established techniques provide highly valuable, practical information. Scanning of brain, kidneys, liver, and thyroid is practical in a general hospital, and the information which can be obtained is necessary for high quality diagnostic service. There is reason for much op-

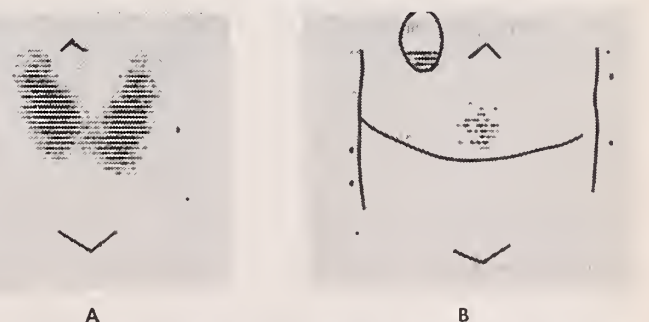
timism about the future; recent improvements have been an important stimulus in more effective scanning.⁶ Many similar improvements in equipment, tracer materials, and techniques can be expected in the future.

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FIGURE 4



- A** Thyroid scan. Enlarged but symmetrical thyroid with uniform uptake. Patient had marked increase in iodine uptake.
B Thyroid scan. Young woman with history of thyroidectomy hyperthyroidism six years ago. Returned because of discrete hard nodule high in right neck. Scan reveals residual isthmus of thyroid and heavy uptake by nodule (not scanned completely but palpable margins outlined by heavy oval line). Nodule was removed and it consisted of thyroid tissue.

RENOVASCULAR HYPERTENSION

Milton F. Bryant, M.D., *Atlanta*

■ The history, physical signs and new diagnostic aids are described and discussed.

RENOVASCULAR HYPERTENSION may be defined as high blood pressure caused by an obstruction in the renal arterial vasculature which may be cured by reconstructive arterial surgery or by nephrectomy. In 1909, Janeway¹ first reported blood pressure changes following reduction of the renal artery circulation. Everyone is familiar with the classic experiments of Goldblatt and his associates² which were reported in 1934. These investigators demonstrated that persistent hypertension could be produced in dogs by partially constricting one renal artery and removing the contralateral kidney. During the next 20 years many patients were subjected to nephrectomy in an effort to cure renovascular hypertension or hypertension secondary to unilateral kidney disease. Smith^{3, 4} reviewed the literature in 1948 and again in 1956 and concluded that only 20 per cent of the patients who had been subjected to nephrectomy were cured of their hypertension.

Important Observation

Wilson and Byrom made an important experimental observation in 1939 in noting that the kidney on the side of an arterial obstruction was frequently protected from the damaging effects of prolonged hypertension. This finding was confirmed in man by Bauer and Forbes⁶ in 1952 and suggests that, if possible, the so-called Goldblatt kidney should be preserved.

By combining their experience in vascular surgery with the available clinical and experimental information, Freeman and his associates⁷ in 1954 were successful in curing a patient with renovascular hypertension by endarterectomizing the obstructed artery and restoring a normal blood flow to the ische-

mic kidney. The literature now contains numerous reports^{8, 9, 10} of patients who have been apparently cured of their renovascular hypertension by appropriate reconstructive vascular surgery.

Diagnosis

The actual number of patients with renovascular hypertension in the general population is unknown. It has been estimated that five to 20 per cent of all hypertensive patients have secondary hypertension due to an obstruction in the renal arterial system. Since renovascular hypertension is potentially curable and has been shown to be a common cause of hypertension, this problem must be considered in every patient with elevation of the diastolic pressure.

As yet there is no one diagnostic procedure which will effectively screen out every patient with hypertension secondary to an ischemic kidney. It has been emphasized by a number of investigators^{10, 11, 12} that many patients with renovascular hypertension can be identified by relatively simple procedures which are available to every physician—even those in the most remote areas. These procedures include a detailed history, performance of a complete physical examination and critical interpretation of the excretory urogram. Of course, final selection of patients for surgery will depend upon evaluation by more specialized studies such as the radioactive ¹³¹

TABLE I
HISTORY

1. Recent onset
2. Recent increase in severity of hypertension
3. Age 20-50
4. Negro race
5. Negative family history
6. Flank pain or trauma
7. Cerebral ischemic symptoms
8. Intermittent claudication
9. Coronary thrombosis

Presented at the 109th Annual Session of the Medical Association of Georgia, May 7, 1963, Jekyll Island, Georgia.

TABLE II
PHYSICAL EXAMINATION

1. Abdominal or flank bruit
2. Murmur over carotid, subclavian or femoral arteries
3. Absent or diminished peripheral pulses
4. Arterial aneurysm
5. Auricular fibrillation, mitral stenosis
6. Papilledema or hemorrhages and exudates in the fundi

renogram,¹³ the radioactive mercury renoscan,¹⁴ separated renal function studies¹⁵ and the aorticorenal arteriogram.¹⁶ It must be emphasized that no one study can be relied upon as a basis for recommending surgery. At the present time one must evaluate the results from a combination of these studies.

Features of Examination

The features in the clinical history and physical examination which may be helpful in detecting renal hypertension are outlined in Table I and II and deserve a few comments. The recent or sudden onset of hypertension is impossible to document in some patients. Examinations for insurance, military service, industrial employment or blood bank records may give clues regarding previous blood pressure levels. A recent increase in blood pressure may be difficult to evaluate in patients with essential hypertension as their pressure may rise and fall with emotional and unknown factors. For some reason, renal hypertension is rare in the Negro race. Patients with essential hypertension frequently have a strong family history of this problem with onset of the hypertension between the ages of 20 and 50 years. However, many patients with renovascular hypertension are between the ages of 20 and 50 so age, per se, is of little value in selecting patients for more intensive study. Recent trauma or flank pain may be associated with a renal vascular accident.

The findings of an abdominal or flank bruit may be of significance. In addition, one should listen for murmurs over the femoral carotid and subclavian arteries. The presence of auricular fibrillation or the history of a recent or old myocardial infarction may indicate renal artery embolism. The presence of an aneurysm, carotid artery insufficiency or peripheral arteriosclerosis obliterans may be associated with an atherosclerotic plaque in the renal arteries. Papilledema or hemorrhages and exudates in the fundi are ominous findings and warrant renal arteriography.

The intravenous pyelogram is reported to be the most important screening test when properly performed and interpreted. It must be remembered that a normal pyelogram may be obtained in the presence of renal artery hypertension. It is important to take films at 30 seconds, one, three and five minutes so that late arrival of the contrast medium in the ischemic kidney can be detected. (Figure 1). A nephrogram film taken at 30 seconds will outline

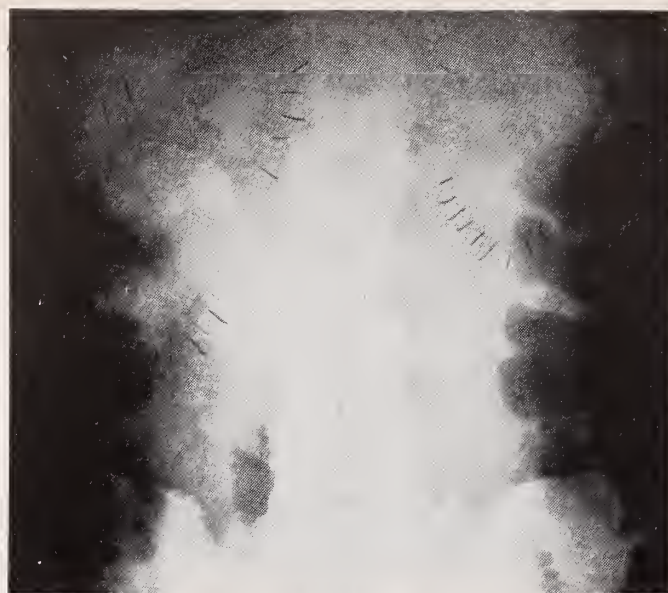


FIGURE 1

Excretory urogram showing a small left kidney with late arrival of the contrast medium secondary to marked atherosclerotic stenosis of the left renal artery.

the renal contour. Any irregularity in outline of the kidney or disparity in the size (a difference of one cm. or more in length) of the two kidneys may be of significance. In the presence of moderate renal artery obstruction, filtered water is absorbed by the tubules resulting in greater opacity due to hyperconcentration of the contrast medium. When the arterial obstruction is nearly complete, visualization of the excretory tract may be faint or nonexistent since little radiopaque dye reaches the kidney.

Special Studies

At the present time it is felt that a radioisotope renogram or a radioactive mercury renoscan should be performed before proceeding with aorticorenal arteriography. In many instances both studies are obtained. Figure 2 shows a normal radioactive Hipuran renogram on the right side and a delay in uptake and clearance of the isotope from the left side indicating ischemia of the left kidney.

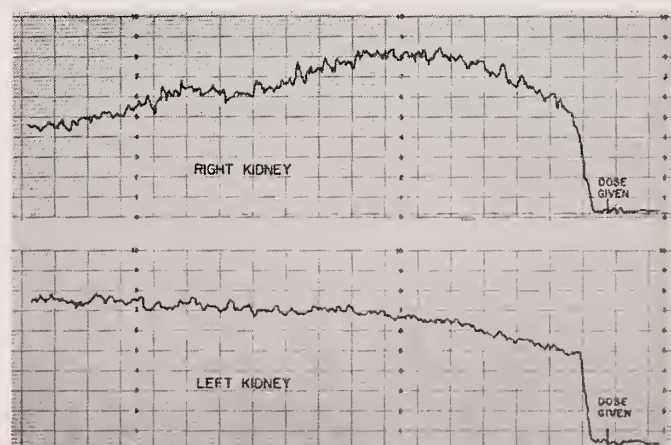


FIGURE 2

Normal radioactive renogram on right side. Left side shows delay in uptake and clearance of the isotope indicating an ischemic left kidney.



FIGURE 3

Hg^{203} renoscan showing decrease in isotope concentration in the lower one third of the left kidney.

Figure 3 is an Hg^{203} renoscan showing decrease in the isotope concentration in the lower one third of the left kidney. A renal arteriogram (Figure 4) revealed atherosclerotic obstruction of an "accessory" artery supplying the lower pole of the left kidney. An endarterectomy was performed with restoration of a normal flow of blood to the ischemic kidney. The patient's blood pressure promptly returned to normal and a post-operative renal scan was found to be normal (Figure 5). Figure 6 is a renoscan showing a small left kidney with decrease in uptake of the isotope secondary to marked stenosis of the left renal artery. Although these studies are frequently helpful, the renogram and renoscan may be normal in the presence of significant renal artery obstruction.

After correlating the history, physical examination, and the findings on excretory urography, with the results of the renogram and/or renoscan, one will usually have adequate information for deciding

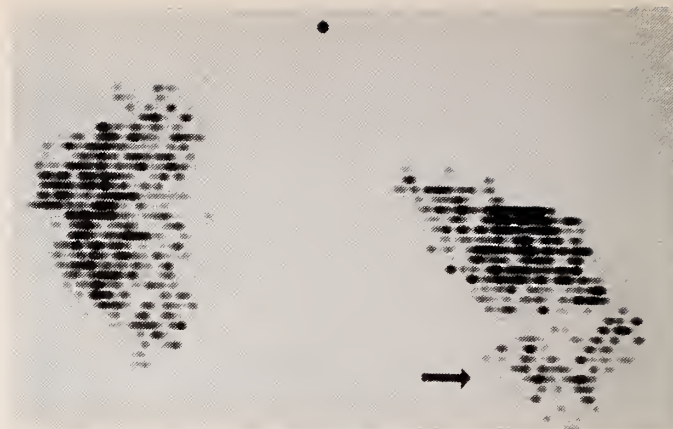


FIGURE 5

Post-operative renoscan revealing normal isotope concentration in the lower one third of the left kidney.

whether or not renal arteriography is indicated. It should be remembered that all of the above studies may be normal and the patient may have renovascular hypertension. In these instances, the experience and the judgment of the attending physician must be used in deciding on renal arteriography.

There are a number of techniques by which the renal arteries can be adequately visualized. The actual method used will depend upon the experience and the preference of the vascular surgeon. The arteriogram in Figure 4 was performed by the percutaneous translumbar route and shows segmental atherosclerotic obstruction of the proximal portion of an accessory renal artery supplying the lower portion of the left kidney. Figure 7 shows the typical picture of fibromuscular hyperplasia—beaded appearance due to multiple, closely placed constrictions with intervening areas of dilatation. Figure 8 is an aorticorenal arteriogram showing atherosclerotic stenosis of the left main renal artery and Figure 9 demonstrates an aneurysm arising from the inferior branch of the right renal artery. All of these patients were relieved of their hypertension by appropriate restorative vascular surgery.

Differential renal function studies are helpful in making certain that the obstruction in the renal vas-

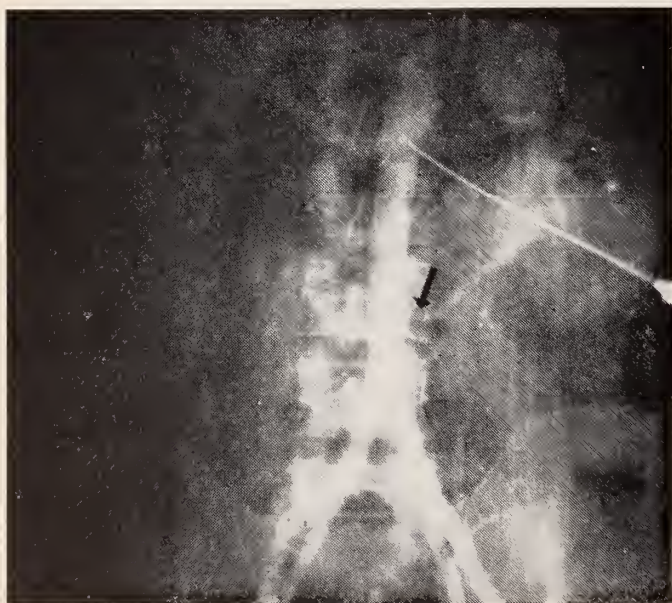


FIGURE 4

Renal arteriogram showing atherosclerotic obstruction of an "accessory" artery supplying the lower pole of the left kidney.



FIGURE 6

Renoscan showing a small left kidney with decrease in uptake of the isotope secondary to atherosclerotic stenosis of the left renal artery.



FIGURE 7

Renal arteriogram revealing bead-like stenosis of the mid-portion of the left renal artery—typical of fibromuscular hyperplasia.

cular system is responsible for the hypertension. A number of authors have stressed the fact that many patients have atherosclerotic obstructions in the renal arteries without resultant hypertension. Technical problems are frequently encountered in accurate specimen collection and many urologists express dissatisfaction with this study. Stamey¹⁵ believes that if one adheres strictly to details, reliable data can be obtained in most instances. A positive test may be explained on the principles of ischemic water reabsorption leading to the following findings on the involved side: a volume decrease by 50 per cent or more, the sodium decreased by 15 per cent or more, the creatinine increased by 20 per cent or more and the p-aminohippuric acid increased by 50 per cent or more, (Table III). Patients with bilateral renal ischemia, segmental ischemia or ischemia due to minimal or moderate obstructions may have equal differential kidney function studies.

Once the diagnosis of renovascular hypertension has been established, surgery is usually indicated. If the patient is in the older age group and is not a good surgical risk, medical management may be the treatment of choice. The concept that patients with renovascular hypertension do not respond to medical measures has been disproven.

The actual procedure used to restore a normal blood flow to the ischemic kidney or kidneys will depend upon the findings at surgery and the experience and preference of the individual surgeon. Figures 10 and 11 outline some of the restorative vascular procedures that have been used successfully.

Patients with elevation of the diastolic blood pressure should be considered to have secondary hyper-

TABLE III
DIFFERENTIAL RENAL FUNCTION STUDIES
POSITIVE TEST

1. Volume decreased by 50% or more
2. Sodium decreased by 15% or more
3. Creatinine increased by 20%
4. PAH increased by 50% or more



FIGURE 8

Aorticorenal arteriogram showing atherosclerotic stenosis of the left renal artery.

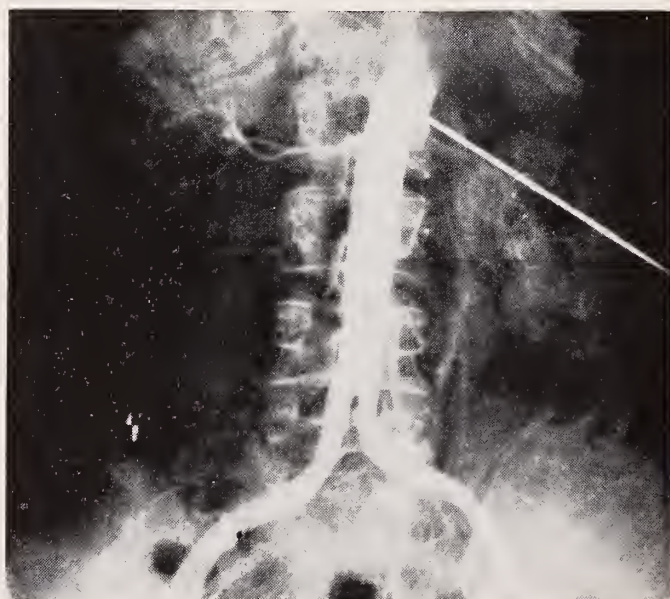


FIGURE 9

Arteriogram demonstrating an aneurysm arising from the inferior branch of the right renal artery.

RECONSTRUCTIVE PROCEDURE UNILATERAL

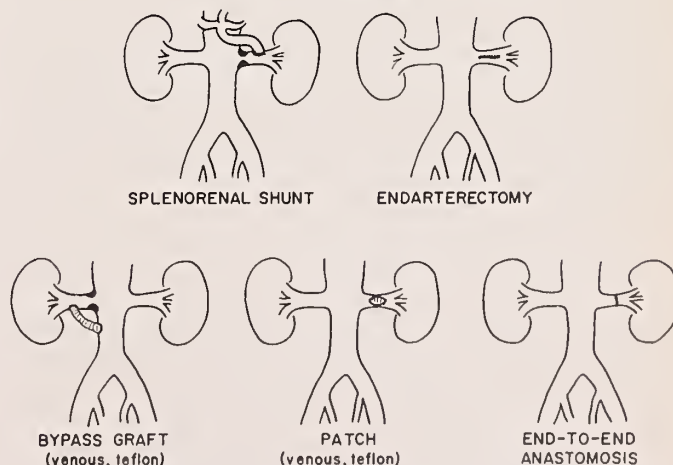


FIGURE 10

Reconstructive procedures that have been used in unilateral renal artery disease.

RENOVASCULAR HYPERTENSION / Bryant

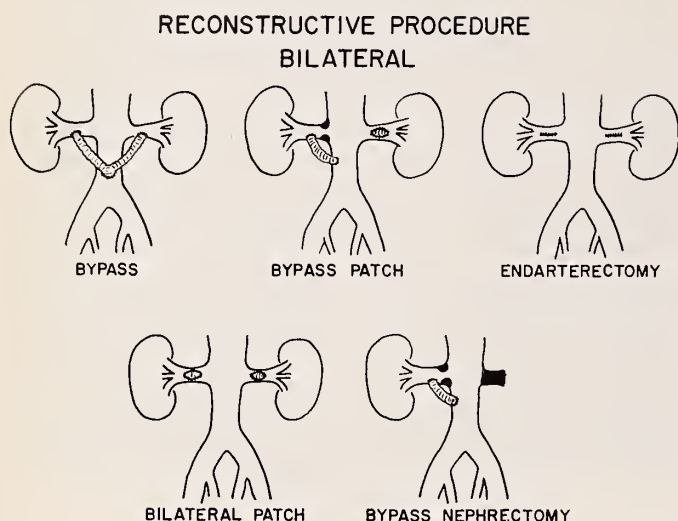


FIGURE 11

Reconstructive procedures that have been used in bilateral renal artery disease.

tension until proven otherwise. A careful history and physical examination along with critical interpretation of the excretory urogram will detect many patients with renovascular hypertension. Special diagnostic procedures (radioisotope renogram, Hg^{203} renoscan, renal arteriography and differential renal function studies) are helpful in selected instances. Once the diagnosis of renovascular hypertension has been established, restorative vascular surgery will relieve the hypertension in most instances.

Medical Arts Building

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AMA MAKES BASIC STATEMENT ON TETANUS IMMUNIZATION

The American Medical Association is establishing an intensive and continuing campaign to improve the immunization of the American people against tetanus. This program started in September, and consists of public and professional education urging the public to get, and renew, inoculations with tetanus toxoid.

Tetanus is completely preventable. The armed services, who provide tetanus immunization routinely, rarely have a case. During recent years an average of 400 cases annually have occurred in the United States. About 60 per cent of those afflicted have died. All of these deaths were unnecessary.

Highest Among Young

The death rate from tetanus is highest among young children. Emphasis therefore should be placed on inoculating them in infancy. Usually this is done with "triple vaccine," including diphtheria and whooping cough along with tetanus toxoid. Three injections four weeks apart, and a booster dose within six to 12 months, will establish immunity.

After immunity has been established, everyone should maintain protection by booster doses every five

years, and a similar booster dose after any injury that might cause tetanus. If immunity has not been established in infancy, an original series of three injections should be given at any age, and similarly followed by booster doses.

Tetanus toxoid is an extremely effective preventive, and it is not known to produce serious side effects. The tetanus antitoxin, on the contrary, occasionally produces serious reactions in people allergic to horse serum. It is now used only for treatment of persons who have failed to get advance inoculations with toxoid. Both tetanus and the danger of allergic reactions can be avoided by preventive inoculations with tetanus toxoid, before injury.

Many adults are unaware of their need for periodic booster shots. Each physician should urge his patients to be immunized and to regularly renew protection against tetanus. A high level of immunity in the population can reduce the present needless occurrence of deaths from tetanus. The American Medical Association urges medical societies and appropriate health agencies to accelerate their efforts in the prevention of tetanus.

PREANESTHETIC EVALUATION OF BLOOD LOSS IN THE TRAUMATIZED PATIENT

Kenneth K. Keown, M.D., and Robert N. Miller, M.D.

Columbia, Missouri

■ ***Clinical signs and symptoms are of crucial importance in this area.***

TRAUMA is always accompanied by shock. The syndrome of shock may be defined by physiological criteria as a progressive vasoconstrictive, hypoxic oligemia. When not reversed, shock progresses to tissue death. In anatomical terms the syndrome may be defined as an existent discrepancy between the circulating blood volume and the capacity of the vascular compartments.

Evaluation of Blood Loss

Evaluation of blood loss prior to anesthetization of a traumatized patient is essential. Certain parameters are useful for evaluation of hypovolemia. A clear understanding of the normal blood volume (Moseley 1962) is necessary, as well as the variance of normal with the habitus, weight, and sex of the individual. As a rough guide, seven per cent of the body weight in kilograms for males and 6.5 per cent in females may be used as estimates of blood volume in normal healthy adults. Normal blood volume roughly approximates the normal volume output of the heart during one minute (cardiac output).

There is no substitute, as yet, for clinical judgment in the evaluation of blood loss. A clinician must be properly trained in the care of a patient as an entity to usefully apply such parameters. Wiggers in 1950 defined four stages in the progression of shock in healthy adults: initial, compensatory, progressive, and irreversible. In the *initial* phase the blood volume was decreased less than ten per cent

and produced no symptoms. The *compensatory* phase included blood volume depletion partially marked by maintenance of systemic blood pressure by means of vasoconstriction of the periphery. During the phase of compensation, peripheral and renal blood flow is shunted to the "core blood volume," perfusing the myocardium, liver, lungs and brain.

The *progressive* phase of shock is characterized by increasingly prominent physiologic alterations including a progressive decrease in the systolic blood pressure with an early elevation of the diastolic blood pressure (narrowed pulse pressure), increasing vasoconstriction, tachycardia, oliguria, and cold sweaty skin. When the systemic systolic blood pressure descends to a level of 50-70 mm. Hg., myocardial depression ensues accelerating the progressive phase of shock.

Irreversible Shock

The fourth phase of shock is the *irreversible* phase which occurs at a volume depletion of 25-30 per cent of the normal blood volume. Multiple theories exist on the causes or even the very existence of irreversible shock from volume deficit alone in the healthy human. The irreversible shock of hypovolemia does exist clinically. Even following adequate volume replacement, the arterial blood pressure remains inadequate for tissue perfusion and death ensues.

In evaluating blood loss in the traumatized patient, blood pressure, pulse rate, hemoglobin, hematocrit, urinary output and central venous catheteri-

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PREANESTHETIC EVALUATION / Keown

zation (Wilson 1962), have in our hands, proven to be valuable clinical aids. Simeone in the 1961 Federation Proceeding on shock quoted a Board of Study on the Severely Injured in World War II which set down three clinical evaluations of shock: 1) slight or compensated, 2) moderate or partially compensated and 3) severe or uncompensated. By parameters measured by this Board of Study these three classifications could be described in the following manner:

1. Slight—Blood pressure over 100 mm. Hg.
Pulse 90-110 per minute
Blood volume deficit less than 20%
2. Moderate—Blood pressure less than 90 mm. Hg.
Pulse 120-140 per minute
Blood volume deficit 25-35%
3. Severe—Blood pressure less than 60 mm. Hg.
Pulse 120-160 per minute
Blood volume deficit 40-50%

In contrast, during anesthesia, a hypovolemic patient may exhibit a slow pulse rate, an elevation of diastolic systemic blood pressure and a progressive narrowing of the pulse pressure. Hypotension and tachycardia are late manifestations of the inadequacy of tissue perfusion.

Illustrative Case

The following is an illustrative case from the University of Missouri Medical Center. A 19-year-old white male was brought to the hospital on February 8, 1963, at 3:30 p.m. He had been injured six hours previously while working with farm machinery. The injuries were multiple and included an incomplete amputation of the right arm, a compound fracture of the right tibia, multiple lacerations, contusions, and abrasions of his entire body surface. The patient was first attended at a small community hospital and was subsequently transferred to our institution. He had received meperidine (Demerol) 75 mg. and metaraminol (Aramine) ten mg. intramuscularly. When first examined by the house staff, the patient was cold, clammy, mildly disoriented, and had a pulse rate of 120 per minute with a systolic blood pressure of 70 mm. Hg. The neck veins were collapsed while the patient was in the supine position. The hematocrit was 43 per cent. No urine output was reported since early in the morning. A venous cannulation of the median cephalic vein in the left arm was instituted and a sample of blood was withdrawn and sent to the blood bank for typing and cross matching. A central venous pressure catheter was inserted by way of the left vein with a baseline venous pressure of 0-2 cm. H₂O. Two units

of plasma were infused rapidly intravenously. Catheterization of the bladder yielded 200 ml. of urine which was normal on analysis. Following the infusion of 600 ml. of plasma and during the infusion of the first unit of blood, urine output was first noted in the drainage bottle. Renal filtration was evidence of improved renal blood flow denoting the total circulating blood no longer was being shunted to the "core." Despite 600 ml. of plasma and 300 ml. of whole blood the central venous pressure did not rise above two-four cm. H₂O. This indicated that the heart readily handled the increase in blood volume by increasing its output. Had heart failure contributed to the hypotension, an increase in venous pressure would have occurred. The patient was anesthetized with nitrous oxide-oxygen and halothane while surgery was consummated without untoward incident. In order to maintain an adequate blood pressure with urinary output, a total of four additional units of whole blood and one unit of plasma were administered without an increase in central venous pressure. Eight hours following completion of surgery and anesthesia the hematocrit had decreased to 37 per cent and on the following day was 32 per cent, indicating redistribution of the blood volume and body water within the vascular compartments.

In our initial evaluation of this patient we concluded that he represented a moderate to severe and progressive state of shock. The favorable response to increases in circulating blood volume confirmed this diagnosis. It is more logical to correct hypotensive states physiologically rather than pharmacologically by the injudicious use of vasopressors.

Summary

In summary, we believe that trauma is always accompanied by shock. The degree of shock depends upon the severity of the injury, duration of injury, degree of infection, previous physical status of the injured patient and the amount of deviation from the normal mechanisms of homeostasis.

The shock syndrome following trauma may be oversimply defined as progressive, vasoconstrictive, hypoxic, oligemia. Stated anatomically, a discrepancy exists between the blood volume and the capacity of the vascular system.

Laboratory data pertinent to the care of traumatized patients should include hematocrit, hemoglobin, blood volume determinations, central venous pressure and urinary output.

The clinical evaluation of the patient is the single most important estimation made by the anesthesiologist.

University of Missouri Medical Center

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1963-64 CALENDAR OF MEETINGS

State

October 9, and continuing for 12 weeks—"Psychosomatic Medicine Conferences" sponsored by the Department of Continuing Education, The Medical College of Georgia, Augusta.

December 5-6—Second Annual Thomasville Medical Seminar, Archbold Memorial Hospital, Thomasville.

December 5-6—Fifth Annual Postgraduate Course in Ophthalmology of the Emory University School of Medicine, Grady Memorial Hospital, Atlanta.

January 14-16, 1964—"Thirteen Cardiacs" sponsored by the Department of Continuing Education. The Medical College of Georgia, Augusta.

February 10-14, 1964—"Hypertension and Its Complications" sponsored by the Department of Continuing Education, The Medical College of Georgia, Augusta.

February 18-20, 1964—"Obstetric Problems in Private Practice" sponsored by the Department of Continuing Education, The Medical College of Georgia, Augusta.

May 3-6, 1964—110th Annual Session of the Medical Association of Georgia, Macon, Ga.

Regional

November 18-21—Southern Medical Association, New Orleans, La.

December 7-8—International Symposium on Hemophilia, Sheraton-Park Hotel, Washington, D.C.

December 9-10—American Society of Hematology, Statler Hotel, Washington, D.C.

December 10-12—Southern Surgical Association, The Homestead, Hot Springs, Va.

January 5-8, 1964—First Annual Postgraduate Seminar in Anesthesiology sponsored by the University of Miami and University of Florida Schools of Medicine, Miami Beach, Fla.

January 13-17, 1964—Postgraduate course sponsored by the American College of Chest Physicians on Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, Miami Beach, Fla.

January 27-29, 1964—American College of Surgeons, Lord Baltimore Hotel, Baltimore, Md.

January 30-31, 1964—Symposium on "Scintiscanning in Clinical Medicine," sponsored by the Department of Radiology, Bowman Gray School of Medicine, Winston-Salem, N. C.

February 12-16, 1964—American College of Cardiology, Roosevelt Hotel, New Orleans, La.

February 29-March 5, 1964—International Academy of Proctology, Deauville Hotel, Miami Beach, Fla.

February 29-March 6, 1964—American College of Allergists, Americana Hotel, Bal Harbour, Fla.

National

September 15, 1963-June 15, 1964—Nine month tutorial program in Cardiology offered by the Institute for CardioPulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

November 18-20—Tenth Symposium, "Aging of the Lung: Perspectives," sponsored by the Hahnemann Medical College and Hospital, Sheraton Hotel, Philadelphia, Pa.

November 21-23—American College of Physicians' First Sectional Meeting (Midwest), Detroit, Mich.

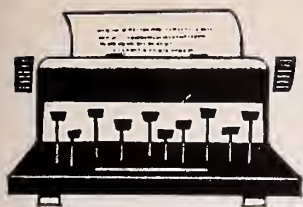
December 1-4—American Medical Association Clinical Meeting, Memorial Coliseum, Portland, Ore.

January 6-March 14, 1964—Ten week Postgraduate course in Tropical Health sponsored by the Stanford University School of Medicine, Stanford Medical Center, Calif.

January 12-18, 1964—Tenth Annual General Practice Review, sponsored by the University of Colorado School of Medicine, Denver, Colo.

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Applewhite, Mary Lou	Emory University Clinic Atlanta, Georgia	Active	Fulton
Asteinza, Jenaro S.	Milledgeville State Hospital Milledgeville, Georgia	Active	Baldwin
Bootle, William A., Jr.	700 Spring Street Macon, Georgia	Active	Bibb
Clay, James R.	Athens General Hospital Athens, Georgia	Active	C. W. Long
Cronic, Frank M.	777 Hemlock Street Macon, Georgia	Active	Bibb
Galler, Edwin J.	4158 Peachtree Road, N.W. Atlanta 19, Georgia	Active	Fulton
Iseman, Joseph W.	848 Peachtree Street, N.E. Atlanta, Georgia	Active	Fulton
Johnson, Robert W.	Boston, Georgia	Active	Thomas-Brooks
Jones, Ransom L.	1783 Washington Avenue East Point, Georgia	Active	Fulton
Lindsey, James B.	Crawford, Georgia	Active	C. W. Long
Majanovic, Mahmud	Box 325 Milledgeville, Georgia	Active	Baldwin
Mayes, Alva L., Jr.	2009 Vineville Avenue Macon, Georgia	Active	Bibb
Merritt, Charles R.	Hospital Drive Carrollton, Georgia	Active	Carroll-Douglas-Haralson
Murray, Walter A., Jr.	1938 Peachtree Road Atlanta, Georgia	Active	Fulton
Pausa, Sergio G.	340 Boulevard, N.E. Atlanta, Georgia	Active	Fulton
Rhame, Marian Levan	250 E. Ponce de Leon Avenue Decatur, Georgia	Active	DeKalb
Robinson, Clark	Church Street Douglasville, Georgia	Active	Carroll-Douglas-Haralson
Romaine, Benjamin W.	907 N. Culpepper Street Quitman, Georgia	Active	Thomas-Brooks
Ruder, Ernst M.	35 Linden Avenue, N.E. Atlanta 8, Georgia	Active	Fulton
Washburn, Lawrence L.	490 Peachtree Street, N.E. Atlanta, Georgia	Active	Fulton
White, Henry C., Jr.	724 Hemlock Street Macon, Georgia	Active	Bibb
Williams, William A.	Building Office Riverside Shopping Center Macon, Georgia	Active	Bibb
Wintrup, Charles K.	275 Buckhead Avenue, N.E. Atlanta, Georgia	Active	Fulton
Zimmerman, Alfred M.	401 Peachtree Street, N.E. Atlanta, Georgia	Active	Fulton



Shock and Vasopressor Agents

SOME of the most potent therapeutic agents introduced into general use in the past decade are the vasopressor agents. There are several of these agents. They occur normally in the body and are known collectively as the catecholamines. These amines serve an important function in body hemostasis and in the physiologic response to stress. The most active of these drugs is norepinephrine which is commercially produced under the trade name of Levophed. Since its introduction in the early 1950's, there has been much knowledge gained about this drug and some changes in the original ideas of its usage. A few remarks about the present status of Levophed would appear worthwhile.

Vaso Constrictor

Norepinephrine is a potent vaso constrictor. It increases the strength of cardiac contractility and decreases the resistance in the coronary vascular bed. With these properties, it is clear that such a drug can frequently be lifesaving in shock secondary to coronary occlusion. There is little dispute on this point. However, upon extending the use of Levophed beyond this situation, there is some divergence of opinion.

When first introduced, this drug was widely advocated in the treatment of hypovolemic shock, post-traumatic shock, and almost any type of hypotensive state. This attitude seems now unwise. The most common cause of shock is still related to inadequate blood volume. In this situation, restoration of blood volume should be the focal point of treatment. All other modalities of therapy should be temporary and secondary to this principle. True Levophed will promptly restore blood pressure in profound shock. However, in the absence of adequate blood volume, this is accomplished by a dangerous reduction of cerebral and renal blood flow. Proper perfusion rate is dependent on pressure versus resistance. If the

resistance is too high, then the blood pressure, though normal, will be inadequate to deliver a proper volume of blood to any given organ.

Cardiogenic Adjunct

Levophed is a valuable adjunct in treating cardiogenic shock. It is not a wise choice in the treatment of hypovolemic shock. These might be called the black and white zones. Between these there is a gray area covering a number of stress situations in which Levophed has been advantageously used, although some discourage its application. Endotoxic shock, severe drug reactions, adrenal exhaustion, spinal anesthesia with shock, and shock related to hypoxia and metabolic acidosis are cases in point. The amount of data available is not yet sufficient to produce a uniformity of opinion in these problems.

The extreme potency of Levophed requires that it be administered only under the most careful supervision, and then only by the intravenous route. Wide variations of blood pressure can occur in minutes. Uncontrolled, this can quickly produce a cerebral hemorrhage. A small extravasation about the needle may result in an extensive slough. Usually venous catheterization is required for safe infusion. A fall in urinary output may mean inadequate renal blood flow and require a change in treatment. Having succeeded in the initial treatment of the critically ill patient, weaning the patient off the drug can be a prolonged, trying problem.

Valuable Addition

With its various advantages and disadvantages, Levophed has been a valuable addition to our armamentarium in the treatment of certain critical states. We know now that it is dangerous, must be carefully used, and does not solve all of our problems. Most certainly it is not a substitute for adequate blood volume.

The Barnstormer

THE YEAR 1963 is almost history. We are at the gate of that chaotic American phenomenon known as the Presidential Election Year. In a very few months the leadership of the nation will be chosen and hence the fate of the nation will be sealed for another four years. When you read this, you have but a few months left to decide if you are going to be effective or ineffective in determining just what that fate will be. It's later than you think.

GaMPAC

In 1962 a group of Georgia physicians met to organize what has come to be known as the GEORGIA MEDICAL POLITICAL ACTION COMMITTEE (GaMPAC). Concern for the tendency of government to drift to the "left," and thus abandon the bedrock principles upon which this nation was founded provided the motivation for this movement.

In the face of determined efforts by certain entrenched political groups to alter our form of government, it became self-evident to the most casual observer that the profession could no longer take refuge behind the lofty, academic defense that politics and medicine do not mix.

Mechanism for Effectiveness

GaMPAC was thus organized because the need for a mechanism through which medical practitioners could increase their political effectiveness was clear. The Committee instantly recognized that a two directional program was indicated. Its program must include direct political activity, a prime consideration; and education, which must precede any effective political action.

Political education, therefore, became GaMPAC's first objective. Physicians are usually high on the list of those professional groups whose formal education neglected a study of the practical art of politics. Perhaps for this reason many view politics as a complex and mystifying art to say the least. Fortunately there is very little art involved and absolutely no mystery as the student of politics soon learns. However, to convince people of this was to be a difficult task.

To fill the educational void, the American Medi-

cal Political Action Committee (AMPAC) produced a film and practical political course which it named "The Barnstormer." The purpose of the film was to show (not merely tell) physicians, their wives and interested members of other health professions allied with medicine, how to be effective in politics. Unlike most films on this subject, "The Barnstormer" talks down to no one, as it is presented in a sophisticated manner. It is basic, down-to-earth, precinct level politics, where all elections are won or lost.

As of this writing "The Barnstormer" has been shown in four widely separate sections of Georgia. It has been seen by approximately 700 physicians, dentists, pharmacists and their wives. "The Barnstormer" is not an end to political education, but merely a beginning. It is an effort to furnish all viewers with sufficient basic information on which they may build a storehouse of working knowledge of practical politics.

Political Intrusion

Because politics has intruded upon the practice of medicine, it not only behooves the physician, but also becomes essential that he learn the fundamentals of successful political action. This is not true because of any academic appreciation of the practical art which GaMPAC wishes to impart. Rather it is because the future of the practice of medicine is in jeopardy and the solution of the problem is not medical but political.

GaMPAC sponsored the majority of the showings of "The Barnstormer" in Georgia, but not without some misgivings. It realized that it was asking for valuable time out of the busy schedule of all physicians. Realizing the consequences of failure to educate ourselves on a matter which each day assumes a most important role in our lives made the decision for GaMPAC.

Education and organization are things that belong to the year 1963. Political action, effective and conclusive, is the job for 1964. The only way to achieve this to a degree equal to the task is through organization. GaMPAC needs your support; and medicine, in the worst kind of way, needs GaMPAC.

Grief

A PICTURE frequently encountered in almost every type of medical practice is grief. And with surprising frequency it is not diagnosed. To speak of diagnosing grief implies that it is a specific disorder. This is certainly the position taken by George Engel of the University of Rochester Medical Center. In his recent article, "Is Grief a Disease?" Engel gave a number of arguments in support of this position. Specific disease or not, in its basic form, it certainly has the characteristics of a syndrome or reaction pattern with appropriate measures for treatment and resolution.

Reaction to Death

Usually, of course, grief is the reaction to the death of an emotionally important relative. However, I have seen an indistinguishable picture in a widow at the time her youngest son entered college, in a railroad engineer during the months after his retirement, and in an immigrant woman whose home was condemned and destroyed in order to build a hospital parking lot.

Erich Lindeman, reporting on reactions to the Cocoanut Grove disaster in Boston, noted five pathognomonic signs in acute grief reactions. They are: (1) Somatic distress (2) preoccupation with the image of the deceased (3) guilt (4) hostile reactions and (5) loss of patterns of conduct. Each of these signs merits further discussion.

Varying Symptoms

Somatic distress may be described by the patient as difficulty in swallowing or the sensation of a lump in the throat. There may be a feeling of emptiness or a gnawing sensation in the pit of the stomach. At other times symptoms may be referable to the cardiac region. Respiratory difficulties are commonly observed by the examiner in the form of sighing expiration, which the patient describes as shortness of breath. Easy fatigability may be the outstanding complaint. Other more vague or even bizarre symptoms may occur.

Open *preoccupation with the deceased*, when it predominates the picture, provides an obvious clue to

diagnosis. In some instances, this preoccupation may be intense, but will not be mentioned, because the patient has been criticized. "Your trouble is, you have too much concern for the dead," he has been told. "Forget all that and live for the living."

Guilt may take many forms. Preoccupations with the deceased may be colored by self-blame for inattention, failing to communicate feelings of love, failing to live up to "his expectations," for "not granting his last wish," or not doing "the only thing he ever really asked me to do." Guilt may also be seen in the form of self-denial or socially destructive acts of self-punishment, or even an uneasiness about going to church or otherwise appearing in public.

Hostile reactions may be overt, and may at times be directed toward physicians, nurses or other professionals whose activities have brought them onto the family scene. Misunderstandings and lawsuits between family members, regarding property settlements, are not unusual. But perhaps the most common form of hostility is not direct, but rather a state of irritability and irritation . . . a chronic disposition of peevish disapproval of those about them, perhaps noted only in the patient's facial expression.

Loss of patterns of conduct often takes the form of aimless acts or of starting a task and then not completing it. There may be an extreme dependency on outside stimulation for initiating and completing activity. If this stimulation is toward drinking, sexual promiscuity, gambling or the like, the physician is apt to encounter distress on the part of other family members.

Six Months' Duration

"Normal grief" lasts approximately six months. More misleading, however, are those instances in which grief is delayed, prolonged, compounded or masked by the onset of a psychosomatic disorder such as ulcerative colitis, asthma, thyrotoxicosis or diabetes mellitus. Where unresolved grief is present, the patient usually mentions his loss, though at times only in a very minor way. Careful questioning in such instances usually reveals evidence of inadequate mourning, both qualitatively and quantitatively.

The working through of the emotional reaction to loss consists first of an intensification of the original

Dr. Phillips is Associate Professor, Department of Psychiatry, State University of New York, Upstate Medical Center, Syracuse, New York.

attachment, then the open expression of a wide array of feelings created by the loss as well as many occurring prior to it, and finally, the reinvestment of interest in new activities, and in the future.

While both psychotic and severely neurotic grief

reactions usually require the attention of a psychiatrist, general practitioners and other specialists can play an important role in early recognition, and in the treatment of the great majority of cases where symptoms are less severe. Certainly all of us as physicians must be alert to the frequency and importance of grief in human experience.

Richard H. Phillips, M.D.

GEORGIA GENERAL PRACTITIONERS HOLD FIFTEENTH ANNUAL SESSION IN ATLANTA

Georgia General Practitioners gathered at the Atlanta Americana Motor Hotel in Atlanta, October 10-12, 1963, for their Fifteenth Annual Session. Highlighted on the scientific program were members of the faculties of three Southern medical colleges — The University of Tennessee College of Medicine, Memphis; the Medical College of Georgia, Augusta; and the Medical College of South Carolina, Charleston.

Social events included the traditional President's Banquet and Social Hour, and this year an added attraction, an "Oyster Party" for all attending physicians and their wives co-sponsored by the GAGP and Marion Laboratories. Approximately 35 Commercial Exhibitors were represented at this session.



GAGP Past-President, W. Frank McKemie, M.D., Albany
Guest Speaker Cetin Kaya Aydar, M.D., Augusta
Guest Speaker Roy Witherington, M.D., Augusta

The guest speakers and their topics included Harwell Johnson, M.D., Memphis, "The Surgical Management of Jaundice;" Alvin J. Cummins, M.D., Memphis, "Differential Diagnosis of Jaundice;" and Charles L. Neely, Jr., M.D., Memphis, "Useful Liver Tests."

Frederick P. Zupan, M.D., Augusta, moderated two panels on which three of his Medical College of Georgia colleagues appeared: C. I. Bryans, M.D. presented a paper on "The Office Detection of Gynecological Cancer;" Cetin Kaya Aydar, M.D. spoke on "A Survey of the Infertile Female;" and Roy Witherington, M.D. followed Dr. Aydar with "The Male Infertility Survey."

Members of the Medical College of South Carolina faculty present were Hiram B. Curry, "Occlusive

Cerebrovascular Disease;" James Manly Stallworth, M.D., "Occlusive Vascular Diseases from Surgical Standpoint;" and Harry W. Mims, M.D., "Physical Restoration with Occlusive Vascular Disease."

New GAGP Board of Directors, Officers, Delegates and GAGP Editor for 1964 are as follows:

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Charles G. Green, Waynesboro, Vice President (1963-64)
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W. Mercer Moncrief, Atlanta — 1964
Ben K. Looper, Canton — 1965

EDITOR:

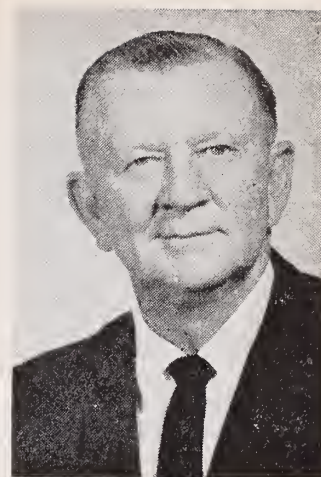
Don Schmidt, Cedartown

Official attendance for the meeting, including Academy members, non-members, guests and exhibitors totaled 251.

The site and date of the Sixteenth Annual Session will be decided at the GP Board of Directors meeting to be held in January, 1964.

CIGARETTES AND PHYSICIANS

GEORGE R. DILLINGER, M.D.



MOST AMERICANS accept the physician as the final authority on health matters. The physician must accept the responsibility of advising his patients and being an example to the public.

Cigarette smoking is one of the proven health hazards. Lung cancer, coronary artery disease, chronic bronchitis, pulmonary emphysema, peptic ulcer and peripheral vascular disease are all aggravated by, if not strictly caused by, cigarette smoking.

Cancer of the lung now kills approximately 41,000 Americans every year — 35,500 males and 5,500 women. Death rates for cancer of the oral cavity, larynx, pharynx and esophagus are five times as high for heavy cigarette smokers as for non-smokers.

The Advertising Media

Tobacco smoke contains a number of carcinogenic agents and some carcinogenic substances. Bronchial tissue cells of heavy smokers show many of the characteristic changes of carcinoma in situ. Such cell changes are rare in non-smokers.

Tobacco is an important cash crop for many Georgia farmers. The cigarette manufacturers spend many millions in advertising, particularly in the radio and television industries.

Mass advertising media direct most of their publicity toward the youth of our nation. The advertising bases its appeal to youth, primarily with athletics and sex. High school data reveal that from 20 per cent to 75 per cent of students smoke.

Associations State

In June, 1961, the American Cancer Society, the American Heart Association, the American Public Health Association and the National Tuberculosis Association in a letter stated that, "On the basis of the weight of scientific evidence on the relationship

of cigarette smoking to cancer, especially cancer of the lung to cardiovascular diseases and to other debilitating and fatal diseases, a commission should be appointed to examine the social responsibilities of business, of voluntary agencies and of government in the education of the youth of America; and to recommend various ways to protect the public, weighing the cost against the benefits to be achieved and seeking a solution to this health problem that will interfere least with the freedom of industry or the happiness of the individual."

No Report as Yet

An Advisory Committee on Smoking and Health was announced by the Surgeon General of the United States Public Health Service on October 28, 1962. So far the committee has made no report.

Three state medical associations (Florida, California and New York) have passed strong resolutions and statements to the effect that smoking is a serious health hazard.

Can we Georgia physicians longer delay accepting our responsibility? Should we not as individuals inform our patients and the public of the extreme hazards of cigarettes? Should our Association at its next Annual Session not pass a strong resolution about cigarettes?

Editor's Note: The Journal of the Medical Association of Georgia during the past eight years has not accepted advertising from cigarette manufacturers.

A handwritten signature in dark ink, which appears to read "George R. Dillinger". The signature is fluid and cursive, with a large, sweeping initial "G".

President, Medical Association of Georgia



CURRENT STATUS OF MAMMOGRAPHY

James V. Rogers, Jr., M.D., and
R. Waldo Powell, M.D., *Atlanta*

THE APPEARANCE of several articles on detection of breast cancer by X-ray in lay publications (*Ladies Home Journal*, April, 1963; *Good Housekeeping*, May, 1963; *Family Circle*, September, 1963) has made an up-to-date understanding of this method by the entire medical profession more urgent. Even now many radiologists not using the Egan technique for mammography believe that the examination is of little value.

Degree of Reliability

Even though a few radiologists reported mediocre to good results with mammography before 1960 it was not until Egan introduced his exacting technique in December of 1960 that soft tissue radiography of the breast became a technically reproducible examination with a high degree of reliability. The Public Health Service, recognizing the potentials of this method for cancer detection, sponsored a study conducted by Egan in which some 24 institutions participated. This was done in order to evaluate the technical quality of mammograms done by various institutions using Egan's technique, to diagnose the accuracy of various radiologists using this technique, and to compare their accuracy with that of Egan on interpretation of the same films. Although the final results of this study are not yet available, all of the participating teams were able to produce technically satisfactory studies with this technique and the overall accuracy of interpretation was above 80 per cent without benefit of clinical information. From other studies it appears that the accuracy of interpretation with knowledge of the clinical findings results in an accuracy of 95 per cent or greater.

Experience has shown that most of the advanced carcinomas of the breast can be demonstrated on

X-ray regardless of the quality of the films. Some of the carcinomas which can be diagnosed clinically cannot be diagnosed on radiographs of good technical quality in certain patients. This is particularly true in some of the younger women with quite fibroglandular breasts in which the lesion may be obscured. On the other hand it has been repeatedly demonstrated that carcinomas may be demonstrated on X-ray when unsuspected clinically. Several radiologists who have done screening mammographic studies indicate that they are able to detect carcinoma of the breast in about one in 500 asymptomatic women over the age of thirty-five.

Complementary Study

Mammography should be used as a complementary study to physical examination of the breast and not as a competitive study. As already indicated, if used in this fashion, it will be accurate in approximately 95 per cent of the cases. In general if used properly the indications for breast biopsy will be increased rather than reduced by the use of mammography. Because of the seriousness of procrastination in the treatment of cancer of the breast, the nature of any dominant mass should be proven by either aspiration or biopsy regardless of the findings on mammography. A negative mammogram should be disregarded if there is a palpable mass. On the other hand, if a mass is demonstrated on mammography, it should be biopsied even though clinical examination is negative.

Soft tissue radiography of the breast is especially useful in the evaluation of large breasts which are difficult to evaluate clinically, multi-nodular breasts, breasts which are negative to physical examination but in symptomatic patients, in patients with a strong

family history of carcinoma of the breast, and in follow-up (yearly) of the opposite breast after mastectomy for carcinoma, since in from five to ten per cent of the patients there will be eventual development of carcinoma in the opposite breast.

Technique All Important

Since technique is all important in deriving the maximum benefits from mammography, all radiologists and other physicians using this examination

should thoroughly familiarize themselves with the Egan technique. Most radiographic equipment will have to be modified slightly in order to produce the low kilovoltage necessary for this technique and a fine grain industrial film will be necessary for maximum detail. In most cases it will be advisable for the physician and his technician to take a short course from a radiologist trained in this technique by Egan.

Emory University Hospital

Approved by Professional Education Committee, Georgia Division, ACS.

GENES AND IMMUNITY TO BE HIGHLIGHT OF AMA MEETING

An outstanding feature of the 17th Clinical Meeting of the American Medical Association, December 1-4 at Portland, Oregon, will be a symposium on "Genes, Chromosomes and Immune Mechanisms," Dr. Huldreich Kammer, chairman of the Scientific Program committee, announced.

The symposium will be held on Monday, December 2, the second day of the meeting. The same subject will be covered in a guest lecture on Tuesday morning by Rupert E. Billingham, Ph.D., of the Wistar Institute, Philadelphia, a world authority on tissue immunity. He collaborated with Peter Brian Medawar, of London, who won the Nobel Prize in Medicine in 1960.

Dr. Medawar received the Nobel Prize for his distinguished contributions to the baffling but highly promising field of tissue transplantation and acquired immunologic tolerance. His main work was concerned with problems of tissue grafting and with tissue inheritance and differentiation. In 1948, at the request of the Medical Research Council, he undertook, with Dr. Billingham and other associates, tissue grafting in cattle to determine the distinction between identical and non-identical twins.

In the course of these and other investigations, he confirmed the theories of the noted Australian scientist, Sir Macfarlane Burnet, with whom he shared the Nobel Prize.

Joining in a panel discussion on genes, chromosomes and immune diseases late Monday afternoon will be

Drs. Robert Koler, moderator of Portland; Levin Grumbach, New York; Arno Motulasky, Seattle; Carl Pearson, Los Angeles, and Robert Blizzard, Baltimore.

Immunization, with special emphasis on the viruses, will be covered on Tuesday's program, along with cancer of the breast.

Outstanding authorities in the diagnosis and treatment of breast cancer will exchange ideas and discuss the newest forms of treatment. The physicians are Ian Macdonald and Richard Martin of the M. D. Anderson Hospital in Houston, and Dr. Maurice Lenz, emeritus professor of radiology at Columbia Presbyterian Hospital, New York.

Also on Tuesday a number of outstanding specialists will discuss the surgical aspects of infection. The doctors include William Kirby of Seattle; Jacob Fine of Boston; and Edwin J. Pulaski of Washington, D.C. They along with Dr. J. E. Dunphy, of Portland, president-elect of the American College of Surgeons, will close this portion of a program with a panel discussion.

Another highlight of the scientific program will be a day-long Tuesday program on kidney problems, including the newest thoughts on kidney acid-base control. A renal symposium will include an airing of the principles of intermittent dialysis as well as the socio-economic problems associated with keeping such chronic uremic patients alive. Speakers and panel discussants include Drs. William B. Schwartz, Jr., Boston; Belding Scribner, S. T. Boen, and John S. Murray, all of Seattle.

CALL FOR SCIENTIFIC EXHIBITS

110TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

Macon, Georgia, May 3-6, 1964

For Information and Applications, Write to:

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THE ETIOLOGY OF PULMONARY EMPHYSEMA

Walter S. Dunbar, M.D., *Atlanta*

DURING THE PAST decade research has brought forth new information in the anatomic, physiologic, and clinical features of pulmonary emphysema, but no really conclusive etiology has been found. Diffuse obstructive pulmonary emphysema usually develops after age 40, and for an unknown reason occurs much less frequently in women. There are a number of interesting theories backed up by various data which attempt to explain its pathogenesis.

Clinical Forms

Dr. Richards at Columbia University considers chronic pulmonary emphysema in three categories: (1) the classic largest group of pulmonary emphysema intimately associated with chronic bronchial and bronchiolar infections; (2) pulmonary emphysema secondary to primary fibrosis, as pneumoconiosis, tuberculosis, perhaps bronchiectasis, etc.; and (3) bullous or "atrophic" emphysema. Often one, two, or even three of these factors may coexist, making it impossible in an individual case to pinpoint the primary etiologic process. Within the category of chronic bronchitis and emphysema, two general clinical patterns emerge: (a) obstructive emphysema with ventilatory insufficiency, some degree of hypoxia and infrequent hypercapnia and cor pulmonale, except terminally; and (b) obstructive emphysema with ventilatory insufficiency and alveolar hypoventilation with early and recurrent or continued cor pulmonale and hypercapnia. Both types are usually, but not invariably, associated with a chronic bronchitis.

Laennec's Theory

Laennec in 1838 first stated that basically the production of emphysema required (1) a chronic bronchitis and (2) increased pressure within air cells distal to the partially obstructed bronchi with resultant destruction of the alveoli. Bronchial infection results in edema or swelling of the bronchial lining and in increased bronchial secretions which partially or completely obstruct the bronchi and bronchioles and overwhelm ciliary activity. During

cough, and especially a paroxysm or series of coughs, the obstruction cannot be evacuated, bronchiolar walls are collapsed, and hence alveolar pressure rises resulting in distension and subsequent rupture of alveolar walls. Secondary bronchial spasm aggravates this process. By this mechanism larger blebs, associated interstitial fibrosis, loss of pulmonary elasticity, and obliteration of alveolo-capillary network by distended and ruptured alveoli develop and progress. Since the major retractive force within the lung is not the elastica, but the intrapulmonic mucoprotein film covering the alveolar walls, progressive emphysema results in increased number and size of alveolar wall fenestrations and hence loss of surface tension forces. This increases air flow resistance.

Inflammation The Destroyer

Leopold and Gough in 1957 autopsied 140 cases of obstructive pulmonary emphysema, and 75 of these cases had severe bronchiolitis with centrilobular and panlobular lesions, while the remaining 65 had only lesions of panlobular emphysema. They noted that bronchioles supplying the destroyed areas of centrilobular emphysema were not consistently narrowed, and hence they felt that inflammation rather than airway obstruction was a more likely cause of destruction of alveoli in these cases. Almost all of the 140 cases had a chronic cough and expectoration, but those with panlobular or diffuse emphysema did not have bronchiolitis, only bronchitis, hence it seems that infection in respiratory bronchioles would seem to play a more distinct role in centrilobular emphysema. A few authors question whether chronic bronchitis leads to emphysema or merely accompanies it, and certainly a small number of patients with emphysema, especially those with ventilatory insufficiency and alveolar hypoventilation, clinically often have onset with dyspnea before cough and expectoration develops. Undoubtedly bronchial irritants, such as cigarette smoke, air pollution by factories, automobiles, etc., are aggravating, if not predisposing factors, and should be avoided.

It would appear that the essential assumption in Laennec's hypothesis, i.e., that partial bronchial obstruction raises the pressure significantly in the lung distal to the obstructed area, is not true, as Lindskog demonstrated collateral ventilation between portions of lung within a lobe in such incidences through the pores of Kohn. He was also unable to produce a large rise in pressure distal to the obstructed bronchus in vitro. Another point against bronchial obstruction leading to emphysema is the fact mentioned below that asthma usually does not lead to destructive emphysema. Experimental attempts in animals to produce emphysema by bronchial obstruction alone have been unsuccessful.

Emphysema and Aging

On examining at post-mortem a single lung from each of 100 consecutive autopsies with an age range from 11 to 90 years, as Azcuy et al did, it is found that the severity of emphysema increases progressively with age up to the seventh decade, and that the morphological spectrum of emphysema blends smoothly into the normal aging lung. This suggests that in cases in which infection with cough, expectoration, and bronchial spasm do not play a part, an aging process may be involved. It is not felt that the development of the barrel deformity of the chest in older individuals leads in itself to destructive changes within the lung. Although some instances of familial emphysema have been reported, heredity probably plays a small role in this disease, but further study of this factor may be rewarding.

Picture More Distinct

In considering pulmonary emphysema secondary to primary fibrosis from pneumoconiosis, tuberculosis, bronchiectasis, etc., the pathogenetic picture is more distinct. In these instances traction emphysema from fibrosis of lung parenchymal with secondary shrinkage occurs and is complicated by bronchial

obstruction. In pneumoconiosis star-shaped foci of fibrosis dilate and distort the first-order respiratory bronchioles resulting in the same clinical picture as that of bronchitis with emphysema, and indeed secondary bronchitis usually develops. Centrilobular emphysema is more common in this group.

Bronchial asthma had been thought to predispose to emphysema in a high degree of cases terminally, but Gough in 1955 studied 17 consecutive cases of fatal status asthmaticus and only one showed bullous emphysema, and this patient had concurrent bronchiectasis as well. The other cases were simply over-distended with severe mucous plugging of bronchioles, but no breakdown of lung tissue to form bullae was noted; hence, destructive emphysema is the exception here.

Bullous Emphysema

Nonobstructive bullous emphysema, a third category of pulmonary emphysema, is characterized by formation of bullae by distension and breakdown of lung parenchyma. Bullae may be a part of diffuse pulmonary emphysema or an isolated lesion. The pathogenesis of these lesions is obscure, but may be related to a pneumonic process in childhood. As the bronchial segments of the lung continue to increase in number of subdivisions even up to age 14, it is possible that a chronic viral bronchitis or prolonged suppurative pneumonia could damage the respiratory bronchioles in a formative stage. These bronchioles might then be subject to bullous changes and/or perhaps be weakened then so that emphysematous changes may develop in later years, when they would be under the stress of a chronic bronchitis, smoking, pneumonia, etc. A small number of patients with emphysema, however, do not have a cough during life, or a chronic bronchitis, even at post-mortem examination.

384 Peachtree Street, N.E.

Prepared at the Request of the Committee on Professional Education of the Georgia Heart Association.

PIEDMONT HOSPITAL WINS HARTFORD FOUNDATION GRANT

Piedmont Hospital's Ferst Research Center, Atlanta, Georgia, has received a \$92,793 grant from the John A. Hartford Foundation, Inc., New York, for a three-year study of chemical coating of blood vessels as a preventive of thrombosis. Preliminary work in the laboratory has shown that dextran has such an effect.

George R. Burt, hospital administrator, and Ralph W. Burger, foundation president, said in a joint announcement that the project would be led by Dr. Walter L. Bloom, Director of Medical Education and

Research at Piedmont. Joint participation by the Georgia Institute of Technology will involve the cooperation of Dr. Don S. Harmer, Research Associate Professor of Physics, who will direct a team of Tech professors in building special testing apparatus. Use will also be made of equipment in Tech's Frank H. Neely Nuclear Research Center and the Rich Electronic Computer Center.

Complete chemical facilities, laboratories and experimental operating rooms will be provided by the Ferst Research Center.



GEORGIA'S NEW YOUTH BILL

Michael H. Trotter, *Atlanta*

THE JUVENILE COURTS of Georgia carry responsibilities substantially greater than those of other courts. The Juvenile Court determines if a child is within its jurisdiction as a result of his conduct and condition and, in addition, it directs a program of care and rehabilitation. As a result of the 1963 General Assembly's creation of an autonomous Division for Children and Youth within the Department of Family Services, the Juvenile Courts will receive assistance long needed in carrying out their heavy responsibilities.

Points of Jurisdiction

Since 1953, the Juvenile Courts have had jurisdiction over all children up to the age of 17 years (1) who are alleged to have violated or attempted to violate any federal, state, or local law or municipal ordinance; (2) who are beyond the control of their parents or other custodian; (3) whose occupation, behavior, condition, environment, or associations are such as to injure or endanger their health, morals, and general welfare or that of others; and (4) who are neglected or living under insufficient and improper guardianship or who are in need of medical, psychiatric, psychological, or other care necessary for their well-being, or who are abandoned.

Some of the Juvenile Courts have been handicapped by a lack of trained staff. The new Division for Children and Youth will be of great help by providing study and diagnostic facilities and personnel for the courts. In addition, the Division will operate the existing institutions for care and rehabilitation and will attempt to diversify and expand these facilities. It will continue to regulate agencies and facilities for child care and child placement in Georgia and will provide care and supervision for dependent and neglected youth.

It may be of special interest to physicians that the Juvenile Courts may cause any child concerning whom a petition has been filed to be examined or treated by a physician, psychiatrist, or psychologist and for such purpose may place the child in a hos-

pital or suitable facility. The Court may also place any child found to be within its jurisdiction (1) on probation or under supervision in the child's own home or in the custody of a suitable person elsewhere; (2) in the custody or in the guardianship of a public or private institution or agency authorized to care for children. Such agencies and institutions must be approved by the Division and a number of the institutions to which commitment may be made are operated by the Division; or (3) the Court may order any other care and treatment it may deem in the best interest of the child.

Whenever a child is given medical, psychological, or psychiatric treatment under order of a Juvenile Court and no provision is otherwise made by law for the support of such child, compensation for such care and treatment, when approved by court order, is a charge upon the county of the child's residence. The Court may require a parent to contribute to the care and treatment of his child within his ability to pay.

Authorized to Provide

The Division for Children and Youth is authorized to provide medical, hospital, psychiatric, surgical, or dental services, or payment of the costs of such services as may be required of those legally within the custody or care of the Division. It may, when necessary, pay for any needed services or facilities, whether operated or provided under public or private auspices, in carrying out its authorized duties and functions.

The new Division for Children and Youth has the potential to upgrade the care, treatment, and rehabilitation of Georgia's dependent, neglected, and delinquent youth. Its success will depend substantially on the personnel of the Division and the availability of adequate funds and staff. It will be a great help to the Juvenile Courts in discharging their responsibilities, especially to those courts presently unable to obtain personnel to provide adequate diagnostic and treatment services.

*Suite 1220
C&S Bank Building*

Prepared at the request of The Medical Association of Georgia. Mr. Trotter is a member of the firm of Alston, Miller & Gaines, General Counsel of The Medical Association of Georgia.



THE NEED FOR MENTAL HEALTH PERSONNEL IN GEORGIA

Addison M. Duval, M.D., and Bernard Holland, M.D., *Atlanta*

RECRUITMENT into the mental health field in the past has lagged not only in Georgia but in the entire United States. One reason is that people working in the mental health field have had little prestige. Pay was no incentive, salaries were extremely low, and working conditions often adverse. Frequently, state mental hospitals were run down and badly neglected. Cultural surroundings and social advantages for employees were few. Professional education was and still is costly. For example, by the time a physician completes a three years residency in psychiatry, between 30 and 40 thousand dollars has been invested on this phase of his medical education.

Effects of Inability

What have been the effects of this inability to recruit mental health personnel? The fact is that we are now facing an acute shortage of psychiatrists, psychiatric social workers, nurses, occupational therapists, psychologists, plus teachers for the mentally retarded, and other professional and semiprofessionals who must work with the mentally ill, including ministers, child care aides for delinquents, law enforcement and parole officers, nursing home operators, public health nurses, practical nurses and nursing assistants. For the 4,000,000 inhabitants in Georgia, we now have approximately 40 board certified psychiatrists or approximately one to 100,000 persons. According to a recent survey made by Albee on, "Mental Health Manpower Needs in the United States," there is, in the United States, an average of one psychiatrist for every 18,000 persons. In order to bring Georgia up to this national level, 222 additional psychiatrists are needed. This would mean a five-fold increase. Upon completion of his extensive survey, Albee recommended that the num-

ber of psychiatrists be doubled in the United States, which would mean one for every 10,000 persons. In Georgia, this ratio would require a ten-fold increase in the present number of psychiatrists.

A Present Need

Two questions which may arise are, first, does Georgia have a need for additional mental health personnel? In other words, do we have enough mentally ill people who are in need of these services. And second, do we have adequate facilities to provide needed services? It is estimated that 395,000 (or one out of ten Georgians) is now suffering from some form of mental illness. We have 75,000 people who are alcoholics; 20,000 children under 17 who are brought to juvenile courts each year on delinquency or neglect charges; and more people are having marital difficulties, obtaining divorces and committing suicide. There are approximately 120,000 children and adults who are mentally retarded. Ten per cent of these will need hospital care at one time or another during their lives. At least 100,000 school age children are emotionally disturbed. These children are in serious conflict with their parents, brothers, sisters and other children. Some are so disturbed that they need residential treatment care, others hospitalization, and all need the support of their parents who in turn need guidance in order to care for them. We know that there are 12,000 people at Milledgeville State Hospital with serious mental illnesses, and many more walking the streets. This gross evidence of need for psychiatric service speaks for itself.

The answer to the second question concerning adequate facilities is a resounding no! It has been a tradition in the United States for individuals to seek and obtain medical care on a private basis. However, the shortage of psychiatrists in private practice and private hospital facilities together with

Dr. Duval is Director, Division of Mental Health, Georgia Department of Public Health; Dr. Holland is Professor and Chairman, Department of Psychiatry, Emory University.

the high cost of treatment have made these services unavailable to families of average means. It is urgent that Georgia develop an insurance plan covering mental illness like physical illness, so that if and when an individual needs care, he can use this method of payment. State facilities for both resident patients and outpatients are overcrowded and waiting lists are long. Even as these public conditions improve, we should remember that in mental health as well as in physical health, our first line of defense is the private practitioner.

There is an equally urgent need to turn to newer methods of treatment and prevention such as can be provided by community mental health centers strategically located to serve all countries in the state. These centers offer a complex of prevention and treatment services for the mentally retarded, the juvenile delinquent, returnees from mental hospitals, the aged, those with marital problems, the alcoholic—and others who have mental health problems.

Not Standing Still

Despite the numerous gaps in service which still exist, Georgia is not standing still. Since general practitioners and specialists treat more mentally ill patients than any other group in our state, one of the most significant developments in recent years has been the strong emphasis on teaching the various aspects of emotional and mental problems in medical schools, both at the University of Georgia and Emory University. Many nonpsychiatric residents, as part of their training, spend some time in psychiatry learning more about the emotional problems of their patients. One role that the proposed community mental health centers could play would be that of offering consultative psychiatric services to private practitioners. Currently, the Medical College of Georgia at Augusta has nine psychiatric residents in training. Through a cooperative program between Emory University Medical School and Milledgeville State Hospital, there are currently 27 residents in psychiatric training.

At the present time, Atlanta University is the only approved School of Social Work in Georgia. However, the University of Georgia now has plans underway to establish a school of social work. It is hoped that within a few years professionally trained social workers will be available to the state, with some of these going into psychiatric social work. The Georgia Department of Public Health and the Department of Family and Children's Services have a stipend program whereby social work students are sent to

schools of social work for professional training.

The University of Georgia is improving its clinical psychology training program and it is hoped that in the near future there will be expansion of an approved program there. Presently, Emory University's Department of Psychology does not have a clinical psychology training program, but it is hoped that such a program can be developed.

Expanding Personnel

Theology seminaries in Georgia are teaching clergymen something about the problems of the mentally ill. The Alcoholic Rehabilitation Service of the Georgia Department of Public Health, through the Georgian Clinic in Atlanta, is developing a one to two year clinical internship for clergymen.

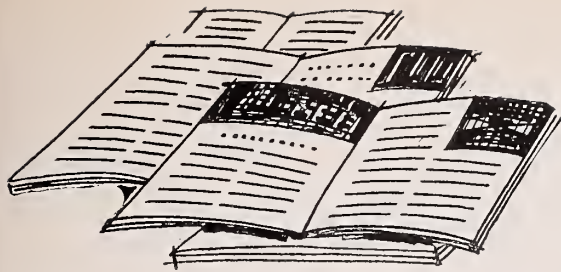
Nursing schools throughout the state have become increasingly aware that their nurses need additional psychiatric training. Some universities are planning to introduce the degree of M.S. in Psychiatric Nursing or Nursing Education.

With the shortage of psychiatrists, psychologists and other personnel in mental health professions, how do we staff our expanding statewide program? Through the new 12½ million dollar Georgia Mental Health Institute, now under construction in Atlanta, which has as its main goal the training of mental health personnel, we hope to provide the future personnel to staff these services.

We believe the image of the mental health worker is now undergoing a change. No longer is he or she thought of as someone who perhaps couldn't "make the grade" in other fields. If we want additional people to enter the mental health profession, we must provide a similar high prestige such as that given the medical profession. We have to see to it that adequate pay is provided for services, and that working conditions—cultural and social surroundings and opportunities—are on a par with those in other professions. We must be able to provide educational opportunities as well as financial support through scholarships and stipends. One of the recommendations of The Joint Commission on Mental Illness was that the federal government invest a large sum of money in the education of mental health workers. So far, in the United States, we have put billions of dollars into medical education, but we have put very little money into the education of allied workers in the mental health field.

Even in the face of great need for additional professional mental health personnel, we believe that Georgia is moving forward in the mental health field and we are optimistic for the future.

Prepared at the request of the Sub-committee on Mental Health of the Medical Association of Georgia.



Nasal Polyps and Cystic Fibrosis

NASAL POLYPOSIS and chronic suppuration of the paranasal sinuses is seen frequently in patients with cystic fibrosis. Operation is indicated when the polyps obstruct the airway completely or when the chronic sinusitis is refractory to medical treatment. It is advised that all children and adolescents with nasal polyps, polypoid changes or chronic rhinosinusitis, be examined to rule out cystic fibrosis.

Rulon, J. T., Brown, H. A., and Logan, G. B., Nasal Polyps and Cystic Fibrosis of the Pancreas *Arch. Otolaryng.* 78:192, 1963.

Cat Scratch Disease Encephalopathy

NEUROLOGIC COMPLICATIONS are rare in cat-scratch disease. Most such patients have encephalitis. Sensory loss is uncommon and spinal fluid is usually normal. Electroencephalographic deviations are common, and the intracutaneous test with cat-scratch antigen is always positive. The mechanism of the neurologic complications is not known.

Steiner, M., and Vuckovitch, D., Encephalopathy in Cat-Scratch Disease, *J. Pediat.* 62:514, 1963.

Cytomegalic Inclusion Disease

THE DIAGNOSIS OF CYTOMEGALIC inclusion disease should be considered in all infants with unexplained anemia, thrombocytopenia, and hepatosplenomegaly and in all other older children with hepatosplenomegaly in association with severe gastroenteritis or pneumonia. Laboratory diagnosis may be made by demonstrating inclusions within exfoliated cells found in urine, cerebrospinal fluid, or gastric washings.

Scott, E. D., Cytomegalic Inclusion Disease, *Missouri Med.*, 60:246, 1963.

Thrombocytopenia and Congenital Heart Disease

THROMBOCYTOPENIA with or without purpura in cyanotic congenital heart disease constitutes a grave surgical hazard. The condition is also thought to contribute to the high incidence of cerebrovascular accidents in congenital heart disease.

Verel, D., Thrombocytopenia in Congenital Heart Disease, *Brit. Heart J.* 24:92, 1962.

Allergic Rhinitis

USUALLY NASAL BLEEDING in children is ascribed to injury to the nasal mucous membranes, which itself is a result and not a cause. Chronic or recurrent rhinitis is usually allergic in origin and the inflammatory condition it produces in the mucous membranes causes the child to rub his nose upward with a palm. This allergic salute is a known cause of trauma to the nose. Allergic rhinitis is a common cause of recurrent epistaxis in children.

Editorial, Allergic Rhinitis: Common Cause of Recurrent Epistaxis, *Pennsylvania M.J.*, 65:690, 1962.

The Nurse Today

"WHAT OF THE NURSE TODAY? Is she really very different from her counterpart at the turn of the century? Of course, she is. As different as every other individual is different. Where has that noble, dedicated woman gone whose praises one hears sung from every side? She's gone where the noble, dedicated physician who sat at his patient's bedside for hours has gone. Gone where the neighbors who rallied around the family in distress have gone. Gone where the apothecary, and the corner grocery man, and the horse drawn fire engines, and the uncorrupt public officials are gone. Lost in time but not forgotten. Time not only heals; it tends to magnify the virtues and ignore the evils.

Actually, the basic concepts of nursing are not changed at all . . . Administrative procedures in hospitals become increasingly complex as hospitals have joined big business and become the fifth largest in the nation. Nurses will continue to occupy themselves with administrative procedures to the exclusion of other activities until their employers make other arrangements. As for the shortage of nurses, there is no question that the shortage that seems to exist would be relieved in large measure if nurses nursed and other people took over the activities that do not require the unique kind of preparation possessed by nurses. In fact, it is quite possible that no shortage would then be evident."

Flores, F.—The Role of the Graduate Nurse Today—*N.E.J. Med.* 267:487, 1962.

Clinical Concepts / Continued

Lead Excretion

A SPECTROCHEMICAL STUDY of the urine and blood of a group exposed to lead for several years but without obvious signs of intoxication was made to determine the porphyrin and lead content before and after a provocative dose of penicillamine. Lead excretion in exposed persons before penicillamine was less than in apparently normal persons, while porphyrin levels were higher. The effect of penicillamine was shown in a definite increase in lead excretion and a decrease in porphyrin excretion.

Wyllie, J., Petermann, H., and Peterman, E., Effect of Penicillamine in Promoting Lead Excretion, *Canad. Med Assn. J.* 88:1155, 1963.

Sclerema Neonatorium

SCLEREMA IS A PATHOLOGIC PROCESS of newborn infants which is as nonspecific as fever, dyspnea, or

dehydration. Sclerema is confined to the neonatal period and first months of life, probably because of pathophysiological limitations imposed by the infant body. When observed in a moribund infant it is a sign of impending death. At other times it is a sign of severe toxicity necessitating specific treatment of the underlying disease process.

Warwick, W., Ruttenberg, H., and Quie, P., Sclerema Neonatorium—A Sign, Not a Disease, *JAMA* 184:680, 1963.

Bloch-Sulzberger Syndrome

THE BLOCH-SULZBERGER SYNDROME (incontinencia pigmenti) is another disorder which must be included in the differential diagnosis of neonatal seizures. The typical early skin changes, along with rather constant teeth and eye disorders, make for a rather consistent syndrome.

McPehrson, A., and Auth, T., The Bloch-Sulzberger Syndrome, *Arch Neurol* 8:332, 1963.

WHEN YOUR PATIENT FILES FOR DISABILITY BENEFITS

Sixteen thousand Georgia residents are expected to file claims for disability insurance benefits under the Social Security Act during the next 12 months. Judging from past experience, about two-thirds of these people will be found disabled. Currently, more than 21,900 disabled Georgians and 19,000 of their dependents are receiving social security disability benefits at a rate of 2¼ million dollars a month. Almost every practicing physician in the state is asked by his patients from time to time to furnish medical evidence in support of their claims for disability benefits. Last year about 37,000 medical reports were submitted to the Social Security Administration on behalf of Georgia applicants. The cooperation of Georgia physicians in providing needed medical data has been indispensable in administering this program.

Who Makes the Disability Determination?

The medical reports, together with the application and a report of the district office interview are forwarded to a disability determination group in the Division of Vocational Rehabilitation (located in Atlanta) where the disability determination is made.

In the State agency, each claim is reviewed by a two-man disability evaluation team which consists of a physician and an experienced disability evaluator trained in the vocational aspects of disability. To assure that disabled persons in all states receive uniform consideration, disability determinations made by the evaluation team are reviewed by professional personnel, including physicians, in the Baltimore headquarters of the Social Security Administration.

When making the disability determination, the State agency also decides whether the claimant has rehabilitation potential. If it is felt that the individual may benefit from vocational rehabilitation services, his case

is referred to a vocational rehabilitation counselor for further consideration and a possible interview.

What Facts Are Needed?

Since the evaluating physician does not examine the claimant personally, he must depend solely on reports from practicing physicians and other medical sources for the factual data on which to base his decision. The evaluating physician uses these written records as a basis for reaching independent conclusions concerning the impairment and its effect on the individual's capacity for substantial work. He can form an accurate picture of the impairment only if the reporting physician has given, in addition to his own diagnostic, prognostic and therapeutic conclusions, the clinical and laboratory data which underlie these conclusions.

The report should, therefore, contain sufficient history to determine the date of onset and course of the disease, reports of physical findings, results of diagnostic tests, and a therapeutic history. Of special importance is information about how the impairment affects the patient's ability to perform the physical and mental functions needed for work; i.e., his ability to walk normally, to stoop or bend; to use public or private transportation; to manipulate common objects; to see and hear; to speak coherently and understandably and to perform any other activities necessary to work. An incomplete medical report often necessitates correspondence with the reporting physician for the purpose of obtaining additional information. Such recontacts place a burden on the physician and delay service to the applicant who is entitled to a speedy evaluation of his claim.

To the extent possible, the report should describe the patient's condition from the time he says he first became unable to work. This is important because much

of the disability decision depends on time factors. If an application is filed without undue delay, benefits can be retroactive to the first month after the expiration of the six-month waiting period; also an applicant may lose his insured status (and thus his entire eligibility for benefits) unless the date he first became disabled can be medically established. The impairment must be shown to have prevented him from working at a time when he had social security credit for at least five out of the ten preceding years.

Diagnosis Versus Function

As a rule, to evaluate the functional limitation caused by impairments, the State agency physician needs the same kind of history, physical findings, and laboratory data as the attending physician requires in making his diagnosis and planning his treatment. Certain medical facts, however, have greater relevance to physical capacity than to diagnosis and therapy. For example, the results of a ventilatory study or of a calculated oxygen-consuming capacity procedure are more significant to physical capacity evaluation than to diagnosis.

One Out of Every Three

About one out of every three Georgians awarded disability insurance benefits has a primary diagnosis of cardiovascular disease. If you are describing heart disease in your patient, general terms such as "mild," "moderate," or "severe" are helpful, but, unless supporting facts are included, the reviewing physician does not have the precise data he needs to assess your patient's remaining capacity for work. The medical report should include cardiac size as shown by P.M.I. and X-ray. Serial blood pressure readings in patients with hypertension

are often helpful. E.K.G. interpretations should be accompanied by descriptions and actual findings. Comments should be included as to the presence and extent of edema—as measured by physical findings, weight change with diuretics, etc. The report should also show the level of exertion that results in dyspnea and/or angina and the clinical characteristics of these symptoms.

Characteristics of Symptom

Where dyspnea is present, it is necessary to know the characteristics of this symptom in order to accurately evaluate disability. When was it first noticed? Is it persistent or intermittent? Is it progressive? How does it relate to exercise? Dyspnea should be expressed in terms of the number of steps that can be mounted, or the distance in blocks that the patient can walk, and the speed at which these activities can be performed.

Where chest pain is the patient's principle complaint, it is important for the physician to indicate its location, whether it radiates, and how it responds to medication. The severity of angina should be related to specific activity, and circumstances; e.g., eating, walking, emotional stress, and the effects of weather conditions.

On the Way

The reports received from Georgia physicians indicate that we are well on our way to establishing a community of understanding between the attending physician and the administrative agency as to what is required to evaluate functional capacity. Through this improved understanding will come prompt and equitable disability decisions.

*Social Security Administration
Peachtree-Seventh Building
Atlanta*

THOMASVILLE WILL HOLD SECOND MEDICAL SEMINAR

Four out-of-state guest speakers have been slated for the Second Annual Thomasville Medical Seminar to be held Thursday and Friday, December 5-6, 1963, at Archbold Memorial Hospital, Thomasville, Georgia.

Eleven hours credit, Category one for General Practice has been approved. Each of the four speakers will give a 45 to 50 minute lecture each day and there will be question and answer sessions lasting approximately one to one and a half hours following each day's session.

Guest Speakers

The guest speakers and their subjects will be Richard TeLinde, M.D., Professor Emeritus of Gynecology, Johns Hopkins University: (1) Indications for pelvic surgery, (2) Urinary incontinence in women; Davis Boyd, M.D., Senior Surgeon for the Lahey Clinic: (1) Conservation and operative treatment of hiatus hernia, (2) Management portal hypertension with bleeding; George Cahill, Assistant Professor of Medicine at Harvard University: (1) Newer concepts

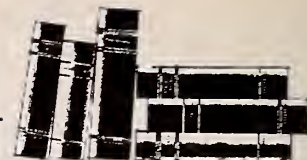
in pathogenesis, diagnosis and treatment of diabetes, (2) Adrenal insufficiency, diagnosis and treatment; and Nathan Smith, M.D., Chairman of the Department of Pediatrics, University of Wisconsin: (1) Iron metabolism and iron deficiency anemia in early life, (2) The child that bleeds.

Planned Recreation

There will be planned activities for the ladies, and on Saturday, December 7, following the meeting, recreation and activities consisting of a Golf Tournament and a possible Tour of the Plantations and a Skeet Shoot will be held. The guest lecturers will be entertained with a Quail Shoot on Saturday morning. Thursday night, December 5, a social hour, banquet and dancing will be held for all participants.

For further information concerning the Seminar contact: George M. Lane, M.D., John D. Archbold Memorial Hospital, Thomasville, Georgia.

PHYSICIAN'S BOOKSHELF



BOOKS RECEIVED

Andrews, George Clinton, M.D., and Domonkos, Anthony N., M.D., **DISEASES OF THE SKIN**, Fifth Edition, W. B. Saunders Co., Philadelphia, 1963, 749 pp., \$16.50.

Beacham and Beacham, **CROSSEN'S SYNOPSIS OF GYNECOLOGY**, The C. V. Mosby Co., St. Louis, 1963, 371 pp., \$7.50.

McLaren, A. D.; Mitchell, Peter, and Passow, H., **CELL INTERFACE REACTIONS**, Scholar's Library, New York, 1963, 107 pp., \$5.95.

Medical Department, United States Army, **PREVENTIVE MEDICINE IN WORLD WAR II**, Vol. VI, **COMMUNICABLE DISEASES, MALARIA**, Office of the Surgeon General, Department of the Army, Washington, D. C., 1963, 642 pp., \$6.25.

Medical Department, United States Army, **PERSONNEL IN WORLD WAR II**, Office of the Surgeon General, Department of the Army, Washington, D. C., 1963, 548 pp., \$6.00.

REVIEWS

DeSanctis, Adolph G., M.D., and Varga, Charles, M.D., **HANDBOOK OF PEDIATRIC MEDICAL EMERGENCIES**, Third Edition, The C. V. Mosby Co., St. Louis, 1963, 457 pp., \$12.75.

THIS COMPREHENSIVE volume represents the fruit of revision and enlargement of the scope of the field of medical emergencies in children. Both student and physician will welcome this extensive exposition of information.

Eleven authors contribute to this third revised edition. Chapters on neonatal and psychiatric emergencies have been added. The section on accidental poisoning is especially commendable. The neophyte will have added security if this compendium is readily available.

Preston D. Ellington, M.D.

Nadas, Alexander S., M.D., **PEDIATRIC CARDIOLOGY**, Second Edition, W. B. Saunders Co., Philadelphia, 1963, 828 pp., \$16.00.

THIS SECOND Edition of *Pediatric Cardiology* by Alexander S. Nadas is a very welcome addition to anyone in the practice of Pediatrics. Basically it is a very carefully written book which, because of the excellence of the subject material, the personal conversational aim of the author frequently showing his innate humor, and the aim to be of practical assistance to the practitioner is enjoyable reading. This in no way detracts from the wealth of material which is well documented by a comprehensive bibliography.

The book is well planned starting with a rather complete discussion of the tools of diagnosis, which is followed by the section on acquired heart disease and then the section on congenital disorders. The body of the text is followed by an appendix which contains a great deal of information in tabular form of normal physical and electrocardiographical reference data, dosage recommendations, and other assorted information to supplement the volume.

This book has been brought to press quickly enough that treatment, both medical and surgical which are now the best that medicine has to offer the child with either acquired or congenital disease, are discussed in a way which still represents current views so far as this reviewer is aware. The book is complete enough that

the physician looking for a differential diagnosis, physiologic information, or therapy of the innocent murmur or the most bizarre findings will find practical assistance. This is a most important reference book for anyone in contact with the pediatric population be he medical student, general practitioner, or pediatrician.

Robert C. Garner, M.D.

Kline, Nathan S., M.D., and Lehmann, Heinz, M.D., **A HANDBOOK OF PSYCHIATRIC TREATMENT IN MEDICAL PRACTICE**, W. B. Saunders Co., Philadelphia, 1962, 124 pp.

AS THE AUTHORS and many other psychiatrists believe, the non-psychiatrist physician has a major role not only in the early recognition, but also in the early treatment of mental illness of all types. In this concise, informal and clearly written summary, the non-psychiatric physician will find valuable information presented in the question-answer style. In the preface it is emphasized that this handbook "makes no pretensions to cover psychiatric theories but does provide insight into the fundamentals of psychiatric reasoning." It attempts to answer some of the most frequently asked questions about non-psychiatric management of emotional illnesses.

Those "Who Should Give Treatment" and "Who Should Be Treated," as well as "Some General Principles of Treatment" are the topics first well described and defined. Emphasis is given to the type of psychotherapy, environmental manipulation and/or somatic therapy which may be indicated. The various psychopharmacological agents with recommended dosages are listed according to their specific actions and indications. An added feature with regard to drug therapy is the description and management of side effects of these psychopharmacological agents as well as contraindications to their use.

In a brief discussion of the different psychiatric disorders the symptoms are first classified according to disturbances of: Mood, Mental Content; Behavior and Somatic Functions. The most common psychotic and psychoneurotic disorders are described. The discussion of depressions, its recognition, treatment and the risk of suicide is well presented. Anxiety reactions, schizophrenia, alcoholism and the organic brain syndromes are also presented sufficiently for the non-psychiatric physician to recognize them and plan for the most appropriate treatment.

This handbook on psychiatric treatment in general medical practice can be recommended very highly not only to non-psychiatric physicians, but also to social workers, nurses and other para-medical personnel who are in close contact with these patients.

Jas. N. Brawner, Jr., M.D.

Reed, Sheldon C., Ph.D., **COUNSELING IN MEDICAL GENETICS**, Second Edition, W. B. Saunders Co., Philadelphia, 1963, 278 pp.

THE PHENOMENAL growth of knowledge in the science of medical genetics during the past few years has given genetic counseling an enormous potential usefulness.

Although the first edition of this book was only

written in 1955, the author found it necessary to completely rewrite this second edition because of the many advances in our knowledge which have occurred since that time. He states that he tried to keep the book short enough and in a light enough vein to encourage a reasonable proportion of the medical profession to read it. It is the opinion of the reviewer that he has been highly successful in doing this.

In a concise but entertaining manner the author presents a considerable amount of information valuable for counseling in most of the common genetic diseases. Bits of humor scattered here and there add to the effectiveness of the presentation. The well arranged bibliography contains recent references to practically every common and uncommon genetic disease.

With genetics assuming such major importance in all branches of medicine, almost any physician, whatever his specialty, should derive a great amount of benefit and pleasure from reading this book.

Edwin C. Evans, M.D.

Bauer, John D., M.D.; Toro, Gelson, Ph.D.; Ackermann, Philip G., Ph. D.; BRAY'S CLINICAL LABORATORY METHODS, The C. V. Mosby Co., St. Louis, 1962, 593 pp., \$10.50.

DR. BRAY'S initial manual of methods used in clinical pathology appeared at a time when physicians were accustomed to performing or closely supervising laboratory determinations on their patients. Almost 30 years later the situation is different. Practicing physicians are concerned with understanding and interpreting results of determinations rather than details of methods. In many medical schools the emphasis in teaching clinical pathology properly has been oriented in this direction. An introductory manual of practical laboratory methods is therefore directed toward pathologists, medical technologists and technicians. In this context the current edition of Bray's book is satisfactory. The chapters dealing with urine and blood chemistry examinations are better than others.

The section treating methods of elevating problems of coagulation is substantial. Other portions of the hematology chapter range afield of methodology, yet they do not adequately treat the subject from any other point of view. As a result there is insufficient detail of theory for the pathologist and omission of methods for technologists. This deficiency is found in other chapters and decreases the usefulness of the book.

The style of the text is easy to read. Most illustrations of pieces of equipment do not augment the text. The black and white illustrations reproduced from the literature are not satisfactory. However, the original illustrations and color plates are good.

This book can be recommended to medical technologists as a good general manual of methods for clinical laboratory examinations.

J. Robert Teabeaut, II, M.D.

Harper, Paul A., M.D., PREVENTIVE PEDIATRICS, Appleton-Century-Crofts, New York, 1962.

THIS BOOK provides an answer to a great many of the common problems encountered in the day to day practice of Pediatrics, whether one is a specialist, generalist, or public health worker.

The author is practical and logical in his approach to

the recognition and management of these problems. Many useful and important facts are presented, while the controversial and irrelevant matters are avoided.

The content of the book is well arranged. Particularly impressive are such chapters as Predictable Problems of Growth and Behavior; Communications, embracing vision, speech, hearing, and reading; and the final chapter which covers such topics as juvenile delinquency, out-of-wedlock births, adoptions, and accidents.

This book will be a valuable addition to the library of anyone who deals with the problems of children. It should receive wide acceptance as a reference and guide in this field.

Thomas E. Bailey, M.D.

RESULTS OF SURGERY FOR PEPTIC ULCER, A Cooperative Study by Twelve Veterans Administration Hospitals. Edited by Dr. R. W. Postlethwait and Dr. James C. Thoroughman as Associate Editor with a foreword by Dr. Lester R. Dragstedt, W. B. Saunders Company, Philadelphia, 1963.

WORKING ON the premise that an individual surgeon cannot properly evaluate results of surgery for peptic ulcer, the authors have compiled an immense amount of data on the types of operation, results, complications and mortality from twelve Veterans Administration Hospitals in various parts of the United States for an eleven year period starting in 1949.

The complications of peptic ulcer are analyzed with great detail and care. The section on intractability is particularly outstanding, as the authors have shown much judgment in arriving at a reasonable definition.

It must be realized that the data is obtained from a particular socio-economic group that may alter statistics for the general public, but the book should be of much value to any physician dealing surgically or medically with peptic ulcer patients.

Charles W. Hock, M.D.

Wells, Benjamin B., M.D., CLINICAL PATHOLOGY, APPLICATION AND INTERPRETATION, Third Edition, W. B. Saunders Co., Philadelphia, 1962, 541 pp.

THE AUTHOR states that his purpose is to offer to medical students and physicians "a guide in the application and interpretation of clinical laboratory studies." Beginning with a clinical problem, useful laboratory tests are named and discussed.

The result is a highly personal book written in a clear literary style. That unique wisdom resulting from wide clinical experience tempers this work and is one of its most valuable features. Properly, the viewpoint of the clinician is given first emphasis and interest in the laboratory is particularly directed to the help which can be given to the clinician.

It is difficult to see how this book will be particularly helpful to medical student or practicing physician. Certainly, it is too long and detailed to serve as a textbook of clinical pathology; similarly, it is incomplete as a textbook of medicine. The physician in practice is likely to find it to be too general to be useful as a reference.

Menard Ihnen, M.D.



DEATHS

HOMER LUMPKIN BARKER, 79-year-old Carrollton physician and civic leader died September 14, 1963.

A native of Heard County, he attended the Heard County Schools and the Medical College of Augusta. He began the practice of medicine in Carrollton in 1912. Last year he received a gold pin for 50 years of service in the Medical Association of Georgia.

Dr. Barker was active in the Lions Club on a local, regional, and international basis. A charter member of the Carrollton club, he had served as its third president and secretary and treasurer, and held life membership on the board of directors.

Dr. Barker was past president of the Carroll-Douglas-Haralson Medical Society and the Medical Association of Georgia. He was past chief of staff of Tanner Memorial Hospital in Carrollton, and was county doctor for the past four years.

He had been a director of the Clinic Hospital in Milwaukee, Wisconsin, a part of the National Soldiers Home.

Dr. Barker was a Mason, a Shriner, and a 50-year member of the Woodmen of the World. At one time he served as worshipful master of the local Masonic lodge.

He was honored as man of the year in 1962 by the Carrollton Chamber of Commerce.

Survivors include his widow, three daughters, Miss Angeline Barker, Clearwater, Florida; Miss Betty Barker, Atlanta, and Mrs. Joseph G. Robertson, Montgomery, Alabama; a niece, Mrs. Dester Neal, Pine Mountain; two sisters, Mrs. Joe Martin, Carrollton, and Mrs. W. E. Denny, Franklin; and three grandchildren.

NIM J. GUTHRIE, 73-year-old Atlantan, died September 23, 1963, at his office in the Atlanta Medical Arts Building of an apparent heart attack.

Dr. Guthrie was a member of the Medical Association of Georgia and the Fulton County Medical Society. He attended Young Harris College and was graduated from the old Atlanta Medical College.

A native of Gwinnett County, Dr. Guthrie practiced medicine in Norcross for 13 years before moving to Atlanta in 1926. He was a member of the Pleasant Hill Baptist Church in Duluth and the Sweetwater Masonic Lodge No. 421.

Survivors include his daughters, Mrs. Ernest Silvey of Atlanta and Mrs. Preston McDaniel of Lawrenceville; sons, J. Richard Guthrie, Sr. of Atlanta and Herbert Guthrie of Decatur; sisters, Mrs. H. R. Williams of Atlanta, Mrs. W. H. Nash of Lilburn, and Mrs. Exah Williams, Mrs. George Brenan, Mrs. Kate Adams and Mrs. L. H. Cain, all of Lawrenceville; brothers, John B. Guthrie of Lawrenceville, R. M. Guthrie of Dalton, T. W. Guthrie of Duluth and H. D. Guthrie of Atlanta, and seven grandchildren and one great-grandchild.

SOCIETIES

BIBB COUNTY MEDICAL SOCIETY met October 1 in Macon for a dinner meeting. The program for the evening was the presentation of "The Barnstormer," a movie sponsored by AMPAC and GaMPAC to further enlighten the doctor on better medicine and better government.

CHEROKEE-PICKENS MEDICAL SOCIETY was host to the NINTH DISTRICT MEDICAL SOCIETY on September 11, at Canton. The program and their speakers included Dr. James P. Isaacs, "External Cardiac Massage;" Dr. Charles Eberhart, Atlanta, "Congenital Bladder Neck Obstruction;" and Dr. A. G. Churchwell and Dr. Bernard Wolff, Atlanta, "Physiological and Therapeutic Aspects of Pulmonary Disease."

Members of the DeKALB COUNTY MEDICAL SOCIETY gave pointers to DeKalb high school coaches at their recent meeting held September 17 in Decatur. The dinner-meeting and forum highlighted "Field Care of Athletic Injuries." Among the speakers were Dr. Fred Allman, Atlanta orthopedic surgeon, and Dr. Ellis Keener, neurosurgeon from Decatur. The society's Athletic Committee is headed by Dr. Luther Vinton of Decatur.

A group meeting of the EIGHTH DISTRICT MEDICAL SOCIETY met the weekend of August 31, at Jekyll Island. In charge of the meeting were Dr. J. Duncan Farris, Waycross, and Dr. Dwight Brown and Dr. Ben Galloway of Brunswick.

SECOND DISTRICT MEDICAL SOCIETY held its semi-annual meeting October 3, in Tifton. Featured on the program were Dr. L. E. Dickey, Jr., Macon, "Fractures in Children;" Dr. William Newton, Moultrie, "Evaluation of the Hypertensive Patient;" and Dr. Daniel Bateman, Albany, "Indications for Surgery in Asthma: A Controversial Subject."

Dr. W. D. Lowery, Albany neurosurgeon, presented slides and gave a talk on Parkinson's disease at the fall meeting of the SOUTHWEST GEORGIA MEDICAL SOCIETY meeting held in late September at Blakely.

"Recognition and Management of Common Dermatoses," presented by Dr. Stuart C. Smith of Tallahassee, Florida; and "Significant Advances in the Field of Neurosurgery," a talk given by Dr. William D. Lowery, Jr., of Albany were the program highlights of the THOMAS-BROOKS MEDICAL SOCIETY which held its quarterly meeting in Thomasville on September 19.

WHITFIELD COUNTY MEDICAL SOCIETY presented a medical symposium supported by Merck, Sharp and Dohme at its meeting held October 17 and 18 at Dalton. Four members of the faculty of the Medical College of Georgia presented programs during

the two days. Dr. Wayne V. Greenberg spoke on "Management of Non-Toxic Goiter," and "Management of Hyperthyroidism;" Dr. Arthur C. White spoke on "Newer Antibiotics," and "Opportunistic Infections;" Dr. George W. Smith spoke on "Head Injuries and How to Evaluate," and "Feasibility of Spinal Tap;" and Dr. J. Robert Teabeaut spoke on "Forensic Medicine," and moderated a Clinico-Pathologic Conference following the second day's session.

PERSONALS

First District

No news submitted.

Second District

No news submitted.

Third District

RICHARD A. DODELIN of Columbus is credited with rescuing and saving the life of a young Columbus construction worker who had fallen to the concrete floor of an elevator shaft while working on a project in Columbus in late August. Dr. Dodelin not only gave the man medical aid but risked his own life when he had to make a precarious climb to reach the injured man.

JOHN L. STAPLETON, Columbus, was recently appointed Muscogee County Physician to succeed POLK LAND who died recently. Dr. Stapleton's duties became effective October 1.

Fourth District

A Griffin physician, VIRGIL WILLIAMS, was appointed in September as the new President of the Georgia State Board of Health. Another former Griffin doctor, JOHN VENABLE, serves as Director of the Georgia State Department of Health.

Fifth District

The Sylvester Kiwanis Club had as its guest speaker September 20, WALTER BLOOM of Atlanta. Dr. Bloom's presentation was entitled, "Diet and Its Effect Upon the Heart."

DAVID H. POER, Atlanta surgeon and civilian consultant in the Department of the Army Surgeon's Office, recently concluded an eight day tour of U.S. military facilities in the Republic of Korea. His tour included a meeting with the Korean Surgeon General and a lecture to the staff of the Korean Capital Army Hospital.

HELEN W. BELLHOUSE, Atlanta, is Vice-Chairman of the Maternal and Child Health Section of the American Public Health Association. In the absence of the Chairman, she served as Acting Chairman of the Section at the 91st Annual Meeting of the Association held in Kansas City, Missouri, November 11-15.

MEDICAL ASSOCIATION OF GEORGIA CONSTITUTION AND BYLAWS BOARD MEETING

THE MEDICAL ASSOCIATION of Georgia Constitution and Bylaws Board meeting of September 19, 1963, was called to order by Chairman W. G. Elliott, Cuthbert, at 2:30 p.m. at the Association Headquarters Office Building, Atlanta, Georgia.

Recent guest lecturer at a postgraduate course in cardiology at the Ohio State University School of Medicine, Columbus, Ohio, was BRUCE LOGUE, Atlanta.

Sixth District

Classes in stroke rehabilitation began in Sandersville September 13. O. D. LENNARD of Sandersville is serving as Chairman of the Stroke Rehabilitation Committee.

H. CHAN WHITE, JR., Macon has announced his association with B. W. FORESTER, W. J. O'SHAUGHNESSY and HAROLD C. ATKINSON at medical offices located at 724 Hemlock Street, Macon.

Seventh District

Two Georgia physicians spoke in Ringgold recently to civic clubs. FRED H. SIMONTON, Chickamauga, spoke on August 21, to the Ringgold Rotary Club, and on August 26, GORDON HIXON of Ft. Oglethorpe spoke to the Ringgold Civitan Club. Both speakers used material from "Operation Hometown" as the basis for their presentations.

Speaking to the Ft. Oglethorpe Kiwanis Club on August 27, was JOHN C. ELLIS of Rossville. Dr. Ellis spoke on the position of the physician with respect to medical care of the aged.

JOHN P. HOOVER of Rossville spoke on September 22, to the Lions Club of Chickamauga. His speech concerned the U.S. President's program for medical care of the aged.

ALFRED H. RANDALL, JR. of Marietta was named in August as a Cobb County District Chairman in the medical division of the United Appeal Campaign which began in August.

LEONARD BROWN, Marietta, spoke on socialized medicine to the East Marietta Lions Club on October 8.

Eighth District

OHLEN R. WILSON, Alma physician, has recently been appointed to the State Fiscal Fitness Commission.

Ninth District

ELTON L. COPELAN, a member of the Toccoa Clinic, Toccoa, attended the Postgraduate Obstetric-Pediatric Seminar at Daytona Beach, Florida, August 22-24.

Tenth District

Speaking on September 30 to the Cobb County Medical Society and the Cobb County Bar Association was JAMES W. HARKESS of Augusta. Dr. Harkess presented a talk on "Socialized Medicine," the speech which he presented to the House of Delegates at the 109th Annual Session of the Medical Association of Georgia, held at Jekyll Island in May, 1963.

In addition to Chairman Elliott, other members of the Committee present included George Alexander, Forsyth; Virgil Williams, Griffin; and Alex Jones, Griffin. Mr. M. D. Krueger of the Headquarters Office staff was also present.

Number of County and District Society Councilors

Chairman Elliott read a communication from the Executive Committee of Council concerning the matter of county medical

The Association / Continued

society and district medical society representation on the MAG Council. This recommendation for consideration by the Constitution and Bylaws Board was as follows: that Chapter IV ("Council") Section 1 (Composition) of the Association Bylaws be amended by adding at the end of the second sentence the following:

"In any District where there is a component county medical society having 100 or more members and there are at least 50 other members in good standing in the remainder of the District, then just one Councilor and Vice Councilor shall be nominated to represent the District at large and no nominations shall be made by such component county medical society with 100 or more members. In any District where there are two or more component county societies each having 100 or more members, then the society with the largest membership shall nominate a Councilor and Vice Councilor to represent such society and no other component society in the District shall be entitled to do so until such time as there would be a minimum of 50 members in good standing in the remainder of the District."

After discussion of this proposal on motion (Jones-Williams), it was voted to approve this amendment and to recommend it to MAG Council for their approval and referral to the House of Delegates.

Additional Councilors for Eligible County Societies

Chairman Elliott then referred to another item of business sent to the Committee for consideration by the Executive Committee of Council. This item concerned the possibility of making an additional recommendation to provide that any county medical society having more than 500 members or a fraction thereof should be eligible to elect two Councilors and Vice Councilors and further that any county medical society having more than 1,000 members or a fraction thereof be eligible to elect three Councilors and Vice Councilors.

After discussion of this proposal and due consideration of the physician population of each District and the larger medical society within that District, it was proposed as follows:

"That any county medical society having 100 or more members would be eligible for a single Councilor and single Vice Councilor (as is now recognized in the present Constitution and Bylaws) and further that when such county societies' active membership reached 400 they would be eligible to nominate a second Councilor and Vice Councilor and further that when such society's membership reached 1,000 that the society would be eligible to nominate a third Councilor and Vice Councilor."

After discussion it was voted on motion (Jones-Williams) to approve the above principle allowing a county society whose active membership met these limitations such additional councilors as they would be eligible to nominate. Dr. Alexander was asked to prepare the actual language for this change in Constitution and Bylaws amendment form for Board recommendation to Council for their approval and referral to the House of Delegates.

Additional Delegates to the House of Delegates

Chairman Elliott stated that the MAG House of Delegates and the Council had referred to the Board on Constitution and Bylaws a proposal concerning additional Delegates to the House of Delegates. After due study of this proposal on motion (Jones-Alexander) it was voted to approve the following and recommend it for adoption by Council and referral to the House of Delegates.

"That the Medical College of Georgia and Emory University School of Medicine may each elect one Delegate and corresponding Alternate Delegate, who would be a doctor of medicine serving in the full facility; be an MAG member in good standing at the time of election; and service for a three year term. Such delegates and corresponding Alternate Delegate should be elected by the full time M.D. faculty of each medical school to represent such medical school.

"That the Georgia Chapter, American Association of Public Health Physicians, may elect one Delegate and corresponding Alternate Delegate, who would be an MAG member in good

standing at the time of election; be a member of the Georgia Chapter, American Association of Public Health Physicians, and serve for a three year term. The Delegate and corresponding Alternate Delegate should be elected by the Georgia Chapter, American Association of Public Health Physicians, to represent the state public health officers."

Dr. Alexander was asked to draft this recommendation in Constitution and Bylaws amendment form for approval by council and referral to the House of Delegates.

Succession of Vice Councilor to Councilor and Replacement of Vice Councilor

On motion (Jones-Williams) it was voted to approve the following change to provide for the succession of Vice Councilor to Councilor and the nomination of a new Vice Councilor.

Amend Chapter IV, Section 1, by changing the words "to elect" in the second sentence to read "to have" and by changing the words "in these elections" appearing at the beginning of the third sentence thereof, to read "in nominating such Councilor and Vice Councilor," and by adding the words "and Vice Councilor" after the word "Councilor" in the third sentence, the second and third sentences of said Section 1 of Chapter IV of the Bylaws to read as amended as follows:

"Component county medical societies having 100 or more active members shall be entitled to have one Councilor and one Vice Councilor directly representing that society. In nominating such Councilor and Vice Councilor, only members of the component county medical society involved shall be allowed to vote and in those Districts which contain the large county medical societies having 100 or more active members, only those members residing in the District outside the large county medical society may vote for the Councilor and Vice Councilor representing that District."

Amend Chapter V, Section 2, by adding the following paragraph at the end of said Section 2:

"If a Councilor dies, resigns, or is unable to fill effectively the office of Councilor because of physical incapacity, he shall be succeeded in such office until the next Annual Session by the Vice Councilor of the District Society or the component county medical society which nominated him. If a Vice Councilor dies, resigns, or is unable to fill effectively the office of Vice Councilor because of physical incapacity, or is serving as Councilor pursuant to the provision of the immediately preceding sentence of this section, until the next Annual Session, the person to fill the vacancy so created shall be the President, Vice President, or Secretary in that order of succession, of the District Society or the component county medical society which nominated the Vice Councilor whose office is being filled, provided that if the first such officer in the order of succession is already serving as Councilor or declines to serve, then the next succeeding officer in the line of succession shall serve as Vice Councilor until the next Annual Session. Both the new Councilor and Vice Councilor shall only serve until the next Annual Session, at which time nominations from the District Society or the component county society will be presented for election to fill out the balance of the term for which the original Councilor or Vice Councilor was elected. Such interim nominations shall be forwarded in like manner as regular nominations for Councilor and Vice Councilor."

Vice President Voting Member of the Executive Committee

Upon the recommendation of the MAG Attorney and by the previous action of the House of Delegates at the 1963 Session in making the First Vice President a voting member of the Executive Committee of Council, it was recommended that the terminology in Section 3 reading: "The Vice President shall not have the privilege to vote, except in the case of the death of the President or in his incapacity as determined by the Council upon the recommendation of the Executive Committee" be deleted. This deletion is recommended on the basis of the fact that the 1963 House of Delegates changed the First Vice President from a non-voting member to a voting member of the Executive Committee, but overlooked this single sentence in Chapter VI, Section 3.

There being no further business the meeting was adjourned at 4:30 p.m.

MAG EXECUTIVE COMMITTEE OF COUNCIL MEETING MINUTES

THE AUGUST MEETING of the Executive Committee of the Council of the Medical Association of Georgia was called to order at 12:15 p.m., in the Wills Memorial Hospital at Washington, Georgia, on August 15, 1963, by MAG President, George Dillinger.

Members of the Executive Committee of Council present included: George Dillinger, Thomasville, President and Chairman; J. G. McDaniel, Atlanta, President-Elect; John T. Mauldin, Atlanta, Secretary; Walker Curtis, Atlanta, First Vice President; John S. Atwater, Atlanta, Treasurer; Addison Simpson, Chairman of Council, Washington; and Virgil Williams, Griffin, Finance Committee Chairman. Also present were Messrs. M. D. Krueger and James Moffett, of the MAG Headquarters Office Staff, Atlanta.

Mr. Krueger read the minutes of the Executive Committee of Council meeting of July 17, 1963, and on motion duly made and seconded, these minutes were approved as read.

Treasurer's Report

MAG Treasurer John Atwater presented a summary-comparison of budgeted and actual operations of the Medical Association of Georgia for the period of January 1, 1963, to July 31, 1963. After due discussion, on motion duly made and seconded, it was voted to approve the Treasurer's report as presented.

Workmen's Compensation Board Nominations

Secretary John Mauldin requested Executive Committee give consideration to forwarding to the Governor two nominations from the Association to serve on the State Board of Workmen's Compensation. By law, the Association is charged with making two nominations for any vacancy or term expiring on the State Board of Workmen's Compensation. On motion duly made and seconded, it was voted to nominate Dr. Duncan Shepard, Atlanta, and Dr. Stewart Long, Atlanta. These nominations were then to be forwarded to the Honorable Carl Sanders, Governor, for consideration.

Radiological Practice Policy

Secretary John Mauldin reported on correspondence from Dr. Neal Yeomans concerning a directive of the Memorial Hospital (Waycross, Georgia) dated July 29 concerning policy established by the governing board relative to radiology. Dr. Mauldin then read his reply to Dr. Yeomans in behalf of the Association which was approved by Executive Committee of Council. It was suggested that Dr. Mauldin get in touch with the Chief of Staff of the Hospital informing him of the jeopardy in professional liability pertinent to this matter.

Industrial Medicine Policy on Ethics

Dr. Mauldin reported that a member wishes clarification on Medical Ethics involved in handling an industrial practice. By general agreement it was the opinion of the Executive Committee of Council, that it was standard practice and quite ethical for a company physician to always see a patient before the patient returns to his job after loss of time due to illness or injury, regardless of which other attending physician had rendered treatment to the patient. Dr. Mauldin was requested to reply to the members on this matter.

Legislative Board Report

Mr. James Moffett reported for the Legislative Board on the following matters:

Mr. Moffett reported that the MAG testimony for the House Ways and Means Committee on the King-Anderson Bill was in the process of being finalized and that the previously appointed special committee would authorize the final draft prior to its being sent to Washington.

Mr. Moffett reported on the MAG State Legislative Committee recommendation on the Health Recodification bill. The recommendation was that an ad hoc committee be appointed and visit with the governor to discuss the organization of composition of the State Board of Health. On motion duly made and seconded, it was voted to defer action on the Legislative Committee request until the September Executive Committee of Council meeting.

Mr. Moffett reported that on a proposed bill to control the use of hypnosis, it was recommended by the Legislative Com-

mittee that such a bill be drawn by the MAG attorney for review by the Executive Committee. On motion duly made and seconded, it was voted to refer this matter to the Mental Health Committee to ascertain the need and type of bill and to further evaluate whether such legislation would be necessary and report back to the Executive Committee of Council at their September meeting.

Mr. Moffett further reported on a proposed bill to require mandatory reporting of alleged child beating with immunity for the physician making such report. On motion duly made and seconded, it was voted that Mr. Moffett summarize existing and proposed statutes on this subject and mail them to the Executive Committee for their study prior to the September Executive Committee of Council meeting.

Mr. Moffett reported on certain sterilization laws which he understood were to be proposed in the 1964 session of the Georgia General Assembly. Mr. Moffett was instructed to find out the progress on the sterilization laws from the MAG Maternal and Welfare Committee and to contact the legislator interested in this subject making MAG services available to him, should he wish assistance.

Mr. Moffett reported on proposed implementation of the MAA section of the Kerr-Mills law, and it was recommended that Mr. Moffett contact the Keymen so that the legislators may be made aware of the urgency of this matter.

Medical Defense Committee Report

Mr. Krueger reported on the Sub-Committee on Medical Defense meeting held July 29, 1963, at which time Dr. Charles S. Jones, Chairman of the Sub-Committee, has presented a draft letter per the St. Paul Company's request. This letter was approved by general agreement of Executive Committee for referral to the St. Paul Companies. The other activities of this Committee were received for information.

District and County Society Councilor Bylaws Recommendation

Mr. Krueger presented a recommendation from Dr. George Alexander, member of the Association Constitution and Bylaws Committee, on the composition of the Council providing for the election of Councilors by the County Medical Society and District Medical Societies with certain limitations. Dr. J. G. McDaniel brought up the possibility of making an additional recommendation to provide that any County Medical Society having more than five hundred members be eligible to elect two councilors and vice councilors and further that any County Medical Society having more than one thousand members be eligible to elect three councilors and three vice councilors. On motion duly made and seconded it was voted to refer this whole matter, which included both the Alexander and the McDaniel recommendations, to the Constitution and Bylaws Committee for report back to MAG Council.

Occupational Health Board Request for Meeting Attendance Funds

President George Dillinger brought in a request from Occupational Health Board Chairman T. A. Peterson, for funds to attend the AMA Congress on Occupational Health to be held at the Jack Tar Hotel, San Francisco, California, September 24, 25, 26, 1963. As Dr. Peterson did not request MAG to budget funds for this meeting, Dr. Dillinger then put his request before Executive Committee. After due discussion, on motion duly made and seconded, it was voted that such funds can only be appropriated by the Council and that the Executive Committee will recommend to the Council such appropriation, but, due to the fact that the meeting in question takes place before the next meeting of MAG Council, it was emphasized that the Executive Committee cannot guarantee favorable action on such reimbursement, if Dr. Peterson chooses to attend the meeting.

Headquarters Office Report

Executive Secretary Mr. M. D. Krueger reported on certain personnel problems within the Headquarters office, and these were referred to Dr. Mauldin and Mr. Krueger for recommendation back to the President and President-Elect prior to any action.

Mr. Krueger reported for information on the compiling of operational policies for the staff of the MAG Headquarters Office. He stated that such policies would be gotten up in a rough draft form and sent to each member of the Executive Committee of Council, which is charged with the operation of the Headquarters Office, for their consideration.

The Association / Continued

Mr. Krueger raised the possibility of the President appointing an ad hoc committee on post neonatal deaths and this data was to be turned over to the President for his disposition.

Finally, Mr. Krueger reported for information on the recent Medical Aspects of Sports Meeting, held under the sponsorship of the MAG School Child Health Committee.

Unfinished Business

President Dillinger requested approval to invite the Southern Medical Association to hold a future meeting in Atlanta at such time as the new Atlanta Auditorium is completed. By general agreement, the President was authorized to issue this invitation in the name of the Medical Association of Georgia.

Dr. Dillinger reported that the MAG-Podiatry Liaison Committee has been appointed and had accepted their appointments and that he would write the Chairman of this Committee, Dr. Fred Allman, about holding a meeting with the Podiatry Association in the very near future.

A communication from the Honorable Governor Carl E. Sanders relative to the National Governors Conference and the recent MAG nominations to the State Board of Health were received for information.

Also received for information, was a physician-hospital staff and governing board problem which is being investigated by the County Medical Society having jurisdiction in the matter.

Mr. Krueger reported that Dr. Charles S. Richardson, Chairman of the Talmadge Memorial Liaison Hospital Committee, was having his full Committee meeting at the Medical College of Georgia on September 15, 1963. This was received for information.

Mr. Krueger presented the final MAG Annual Session program report, and it was generally agreed that Dr. Dillinger should decide with Dr. J. Frank Walker, Speaker of the MAG House of Delegates, about having a national speaker at the First Session of the House of Delegates. It was also agreed that GaMPAC be given the Tuesday, May 5, 11:30 a.m. to 12:30 p.m. General Session, for their programming as they see fit.

Dr. Mauldin reported on the progress of the Georgia Hospital-Medical Council and stated that the Council had approved

the principle of setting up Nursing Home Standards and had also approved the Georgia Association of Nursing Homes membership on the Council.

President George Dillinger reported on the AMA Action on Physician Ownership of repackaging houses and stated this problem must be given attention in the near future. He also indicated that he wished approval of sending a letter to non-AMA members of MAG and such approval was given by Executive Committee for this project.

New Business

A letter from the Student American Medical Association dated August 10, requested that an envelope solicitation from the SAMA be included in the Association's next all member mailing. By general agreement this project was approved and the Headquarters office instructed to comply at Association convenience.

A letter dated August 10, from the Medical Dames Club, which is composed of the wives of medical students who are members of the SAMA at the Medical College of Georgia, was presented. This letter requested an MAG contribution to help send members of the Medical Dames to the Student American Medical Association Auxiliary Meeting to be held in May, 1964. On motion duly made and seconded, it was voted to refer this letter to the Association Budget Committee in November, 1963 for their recommendation.

A letter dated August 6 from Mr. Louie A. Brown concerning a questionnaire authorized by MAG and sent out by Mr. Brown on the subject of the Mobility of Physicians in Georgia was presented. The letter requested Association consideration of an article on this study in lieu of a thesis or of accepting an article and a copy of the thesis. On motion duly made and seconded, it was voted to ask Mr. Brown to send the Association a copy of the thesis and an article for consideration for publication in the *Journal of the Medical Association of Georgia*.

By general agreement, the date and site of the September meeting of the Executive Committee was set for either 12:30 p.m., or 1:00 p.m., on Saturday, September 28, 1963, at the Cloisters, Sea Island, Georgia; this meeting to precede the regular Council meeting which will be held at 2:00 p.m. on that same date. The meeting was then adjourned at 4:20 p.m.

MERCK FOUNDATION ANNOUNCES ADDITIONAL LOANS TO MEDICAL SCHOOLS

George W. Merck Memorial Loan Funds for Interns and Residents have been established at ten additional medical schools, thus increasing the total value of the Funds from \$400,000 to more than \$600,000, it has been announced by Edward Reynolds, President of The Merck Company Foundation.

The additional schools are:

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Memorial Loan Funds were initiated were chosen on the basis of close personal friendships of Mr. Merck with members of the faculties of these schools. The ten additional schools were selected, among other reasons, for the record of their graduates in academic medicine.

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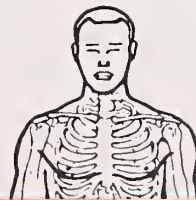
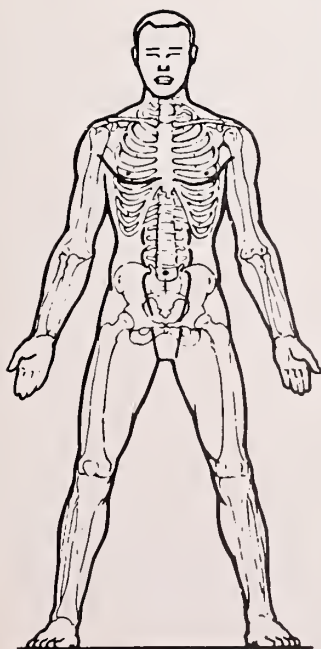
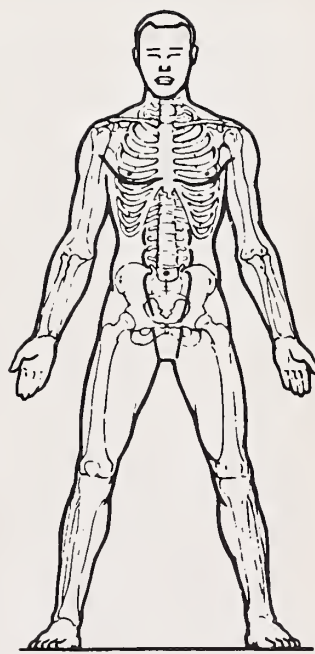
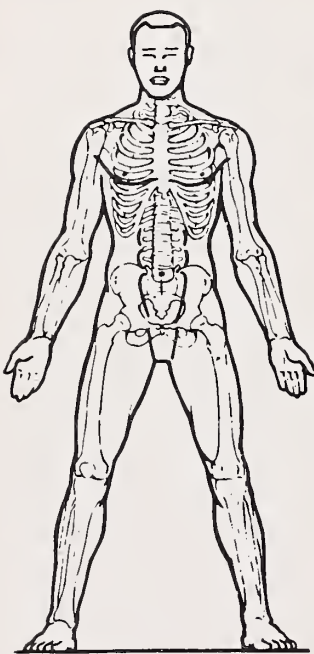
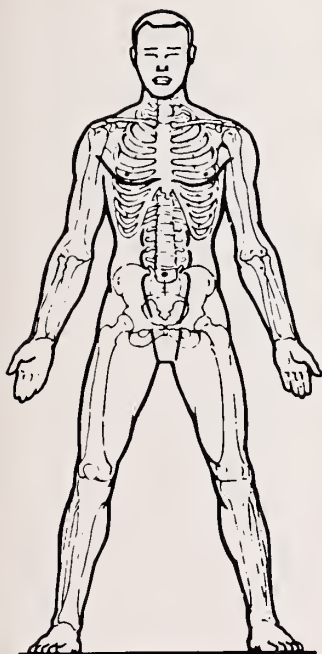
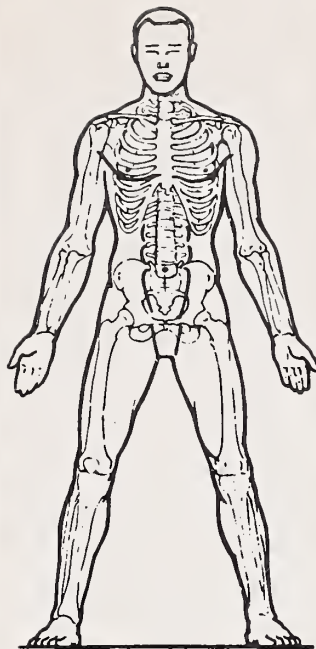
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AUTOMOTIVE CRASH INJURY RESEARCH

See page 521







Contents

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Scientific Articles

ARTERIOMESENTERIC DUODENAL OBSTRUCTION Harold S. Engler, M.D.; Thomas C. Mann, M.D., and William H. Moretz, M.D.	501
VERTIGO - DIFFERENTIAL DIAGNOSIS AND TREATMENT B. W. Armstrong, M.D.	506
BIOLOGICAL DOSIMETRY IN RADIATION INJURY Alexander H. Woods, M.D.	512
DIAGNOSIS AND TREATMENT OF CARCINOMA OF THE PROSTATE FROM A GP VIEWPOINT Samuel L. Raines, M.D.	515

Editorials

AMERICA'S NUMBER ONE EPIDEMIC	521
MEDICINE AND RELIGION	522

Features

President's Letter	523	MAG Council Meeting, September 28	534
Cancer Page	525	MAG Executive Committee of Council Meeting, September 28	537
Heart Page	526	MAG Executive Committee of Council Meeting, October 20	539
Mental Health Page	527	Advertising Index	48A
Abstracts	530	Calendar	529

The Association

Deaths	532
Societies	532
Personals	533

Cover

Illustration of the man that has become the symbol of the Automotive Crash Injury Study conducted by Cornell University, New York. This figure represents the form which Georgia physicians will be requested to fill out as the study gets under way in this state.



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ARTERIOMESENTERIC DUODENAL OBSTRUCTION

Harold S. Engler, M.D.; Thomas C. Mann, M.D., and
William H. Moretz, M.D., *Augusta*

■ ***This paper reports the authors' experience
in managing 12 patients with duodenal obstruction as the
result of arteriomesenteric pressure.***

SINCE ITS FIRST description by Rokitanski⁷ over a century ago, and its reintroduction by Wilkie¹¹ in 1921, there have been infrequent case reports of obstruction of the duodenum by the superior mesenteric artery. This obstruction always occurs at the point where the artery crosses anterior to the duodenum just proximal to the duodenojejunal junction (Figure 1). These reports have appeared under the names Superior Mesenteric Artery Syndrome, Superior Mesenteric Artery Occlusion of the Duodenum, and Arteriomesenteric Occlusion of the Duodenum. Duodenal Stasis, Duodenal Ileus, and Megaduodenum are also terms used for this condition. The term "superior mesenteric artery syndrome" is an inadequate one since it fails to imply that the duodenum is obstructed by the superior mesenteric artery and instead suggests to many the syndrome of intestinal infarction which results from an occluded superior mesenteric artery. "Arteriomesenteric duodenal obstruction" seems the most accurate and most appropriate term to apply to this specific form of duodenal obstruction.

Secondary Form

In addition to the primary form of arteriomesenteric duodenal obstruction, a secondary form may also occur, produced by other abnormalities of this area. Three cases presented here are of this secondary type. Lambert, Fetts, and Turk⁴ in presenting

their unusual case of a duodenal diverticulum which resulted in arteriomesenteric obstruction also used this classification.

Since July, 1956, 12 patients with arteriomesenteric duodenal obstruction have been admitted to the Talmadge Memorial Hospital. Nine of these were of the primary type (Table I) and three were of the secondary type (Table II). Several other patients were thought to have this condition preoperatively but this was disproved at surgery.

Primary Arteriomesenteric Duodenal Obstruction

In the primary group, all were young adults between 24 and 37 years of age, except for the oldest who was 59 and the youngest who was 14. There

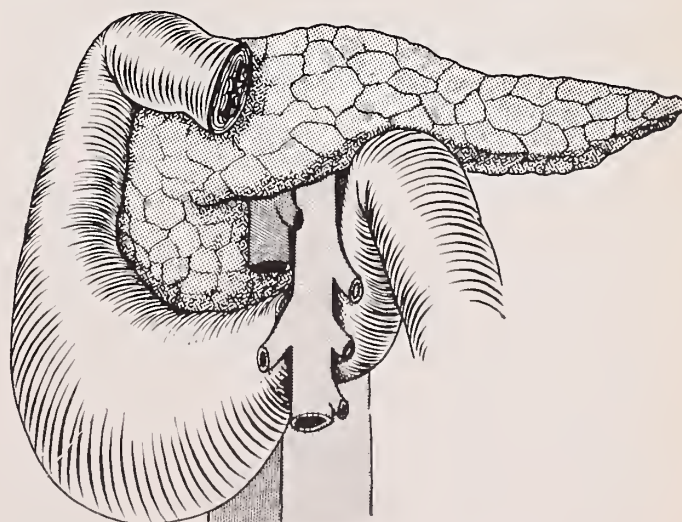


Figure 1

Drawing showing obstruction of the duodenum by the superior mesenteric artery as it crosses anteriorly and the resulting dilated proximal duodenum.

From the Department of Surgery, Medical College of Georgia and Eugene Talmadge Memorial Hospital.

Presented at the 109th Annual Session of the Medical Association of Georgia, May 7, 1963, Jekyll Island, Georgia.

TABLE I
PRIMARY ARTERIOMESENTERIC DUODENAL OBSTRUCTION

No. Age Sex	Other Disease	X-Ray Diagnosis	Response to Medical Regimen	Surgical Procedure	Results
(1) 24-M	Scleroderma	Yes	Not tried	None	-----
(2) 14-F	None	None*	Not tried	Duodenojejunostomy	Excellent
(3) 27-M	Peptic ulcer	Yes	Not tried	Mobilization of duodenum c Billroth II	Good
(4) 31-M	Peptic ulcer & rheumatoid arthritis	Yes	Not tried	Duodenojejunostomy	Excellent
(5) 37-M	Mental retardation Testicular atrophy	Yes	Not tried	Duodenojejunostomy	Initial — Good Late — Fair
(6) 59-F	Peptic ulcer	Yes	Poor	Duodenoplasty	Weight gain, moderate symptoms
(7) 18-F	Ulcerative colitis	Yes	Not tried	Total colectomy	Remained asymptomatic — improved by X-ray
(8) 31-F	Cholelithiasis	Yes	Poor	Duodenojejunostomy	Indeterminate
(9) 29-F	None	Yes	Poor	Duodenojejunostomy	Initial — Good Late — Poor

*Emergency operation without G.I. series

were no cases occurring in childhood as reported by Rabinovitch.⁵ There were four males and five females. One was a Negro and the others were white. Most had some other disease which might possibly have been related. Three had collagen diseases, scleroderma, rheumatoid arthritis, and ulcerative colitis, which had previously been treated with steroids. The patient with scleroderma also had dilatation of the esophagus with disturbed peristaltic action. Three patients had duodenal ulcers and one had a gastric ulcer. One patient had testicular atrophy and mental retardation.

The diagnosis was made by X-ray in each instance, with the exception of one whose diagnosis was made at the time of an emergency laparotomy.

In the primary group, four patients had a trial of medical therapy. This was ineffective in three and

only partially effective in the fourth who later required surgical correction.

Only one of the nine primary cases did not require surgery. Duodenojejunostomy was the operation chosen for five patients. The duodenum was repositioned in three patients, but in none was it done alone.

In one patient the pressure on the duodenum was relieved by releasing the small bowel mesentery from the posterior parietal peritoneum. In another instance the duodenum was freed and its constricted area was widened with a Heineke-Mickulicz procedure. In the other case the duodenum was repositioned in such a way as to release the arteriomesenteric pressure, along with a total colectomy for ulcerative colitis.

The results were excellent in two, good in two,

TABLE II
SECONDARY ARTERIOMESENTERIC DUODENAL OBSTRUCTION

No. Age Sex	Associated Disease	Previous Related Surgery	Other Disease	X-ray Diagnosis	Response To Medical Regimen	Surgical Procedure	Results
(1) 48-M	Thoracic and abdominal aneurysm	None	Episcleritis	Yes	Not tried (No symptoms)	None	-----
(2) 66-M	Leriche synd.	Aortic bifurcation graft	Peptic ulcer Renal calculus	Yes	Yes	None	Good
(3) 40-M	Paraduodenal hernia	Paraduodenal hernia repair	None	Yes	Not tried	Secondary repair of hernia	Too early to evaluate

fair in two and poor in two. One patient has not been followed. In general, the best results were in those with more marked obstruction and pronounced symptoms. Those with poor and fair results had less obstruction and more obscure symptoms and there was considerable doubt preoperatively as to the causal relationship between the duodenal obstruction and the complaints.

Secondary Arteriomesenteric Duodenal Obstruction

Three cases are classed as secondary arteriomesenteric duodenal obstruction. In each of these there was an additional contributing abnormality in the area of the superior mesenteric artery. These three were 40, 48, and 66 year old males. One had an abdominal aneurysm with an X-ray diagnosis of arteriomesenteric duodenal obstruction. Surgery was not recommended in this man because of his overall poor condition. The second case had an aortic bifurcation graft for Leriche syndrome following which he had typical symptoms of duodenal obstruction with evidence by X-ray of arteriomesenteric duodenal obstruction. He responded well to a medical regimen and has remained asymptomatic without surgery. The third patient had a paraduodenal hernia with loops of jejunum entering between the superior mesenteric artery and the duodenum producing obstruction to the duodenum, characteristic, by X-ray, of arteriomesenteric duodenal obstruction. Repair of the paraduodenal hernia was carried out, but the follow-up period is too short for evaluation.

Discussion

The mechanism of arteriomesenteric duodenal obstruction is a compression of the duodenum in the narrow angle between the aorta and vertebral column posteriorly and the root of the mesentery anteriorly (Figure 2). Anything that narrows this angle favors the development of the syndrome. A comparable situation is not seen in quadrupeds since in them the root of the mesentery hangs dependently and widens the angle between it and the aorta. Recent weight loss and lordosis favor the development of this syndrome. Congenital factors play a role in some instances. Anomalous fixation of the gut or mesentery, varieties of shortened mesentery, and conditions which tend to increase the drag on the superior mesenteric artery pedicle may be etiological factors.

A classification of secondary arteriomesenteric duodenal obstruction seems indicated. The three cases presented are instances of changed configuration near the duodenum, one due to an aortic aneurysm and the others due to previous surgery in the area. With the many retroperitoneal operations now being performed (aorta and renal arteries) and the complications that may arise, it is expected that this

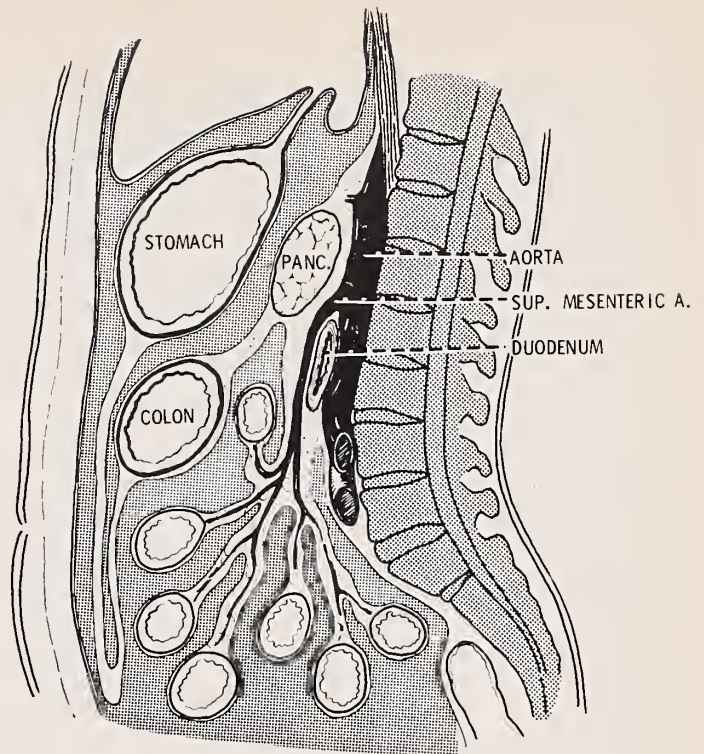


Figure 2

Drawing showing the compression of the duodenum in the narrowed angle between the aorta and vertebral column posteriorly and the root of the mesentery anteriorly.

condition may be seen more frequently. It should be watched for, evaluated by X-ray, and managed surgically if conservative measures fail to give relief. Kaiser, McKain and Shumacker³ list one patient who began to vomit five days after resection of an abdominal aortic aneurysm and, after failure to respond to a brief trial of medical management, was treated surgically with duodenojejunostomy.

Variable Symptoms

The symptoms are variable in degree but usually consist of fullness following meals, nausea, and vomiting without significant pain. The vomitus often contains food eaten 12 to 24 hours before. The severity of the episodes also varies and depends upon the degree of occlusion and the ability of the duodenum to empty itself. Symptoms may be minimal or even absent, the diagnosis being made unexpectedly at the time of upper gastrointestinal X-ray studies. If the duodenal obstruction is more complete, the symptoms are more pronounced, and the term acute arteriomesenteric duodenal obstruction is applied.

There is a tendency to ulceration of the duodenum as noted by Wilkie,¹¹ and Williams and Bowers.¹⁰ In our primary cases there were three duodenal ulcers and one gastric ulcer. Sloan⁸ presented 54 cases of duodenal ulcer known to have mechanical obstruction of the duodenum. He felt that this obstruction was an etiological factor in the formation of the duodenal ulcers. This concept would be substantiated by the present day knowledge of the endo-

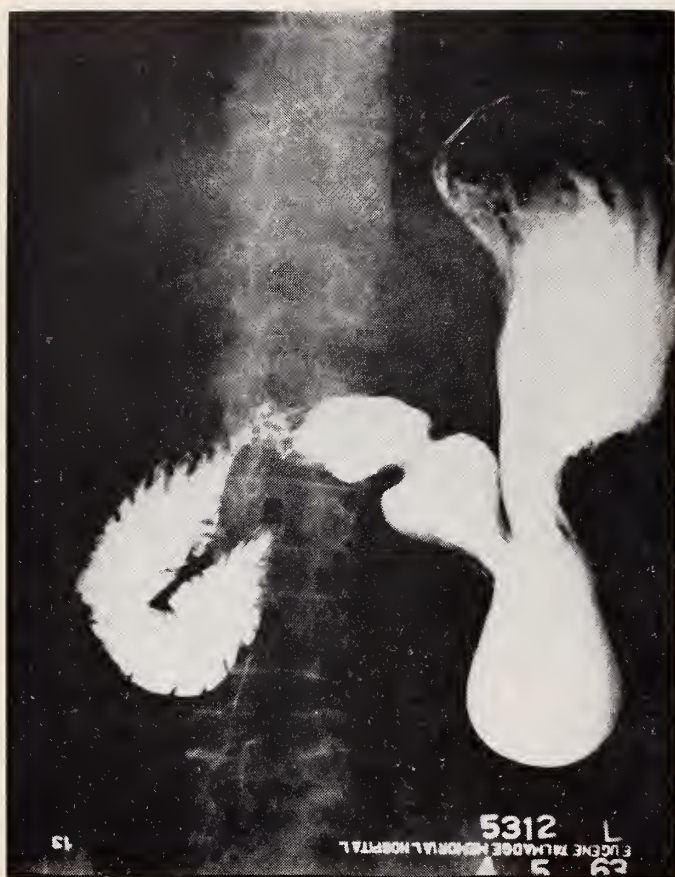


Figure 3

X-ray showing dilation of the duodenum with a sharp cut off of barium flow near the vertebra.

crine activity of the gastric antrum, and its stimulation of high acid levels by over distention.

Diagnosis by G. I. Series

The diagnosis of this syndrome is primarily by G.I. series. Radiological diagnoses were made in all of our cases except one. In that case, the condition was found at the time of emergency surgery. Characteristic X-ray findings include (1) dilation of the duodenum with a sharp cut off near the vertebra (Figure 3), (2) reversed peristalsis in the dilated segment, (3) vigorous to and fro motion of the duodenal contents, and (4) variable degrees of stasis in the duodenum and stomach (Figure 4). Jones² points out that at the time of fluoroscopy the patient should be tipped backwards about 30 degrees so that the superior mesenteric root tends to compress the duodenum more. Our radiologists have noted the obstruction to be increased by this maneuver, to be partially relieved by the erect position, and more fully relieved in the prone position.

Other conditions may simulate arteriomesenteric duodenal obstruction and give a very similar X-ray appearance. During the period of this study we have seen such obstructions caused by metastatic carcinoma to the para-aortic nodes, incomplete rotation of the bowel, pancreatic pseudocyst, and primary

adenocarcinoma of the jejunum. These conditions should be considered in the differential diagnosis of arteriomesenteric duodenal obstruction. These are not considered instances of secondary arteriomesenteric duodenal obstruction because the point of obstruction in these is not directly between the superior mesenteric artery and the aorta.

Complete Evacuation

Medical therapy should begin with complete evacuation of the stomach and duodenal contents as in treating gastric outlet obstruction. This is necessary to remove large particles of undigested food. Decompression of the stomach and duodenum to allow them to regain some of their tone should follow before starting the patient on oral intake. The diet at first should consist of small amounts of liquids or bland feedings and the patient should assume the knee-chest position for 20 to 30 minutes following the meal. Further benefit is obtained by lying prone. In patients with poor anterior abdominal wall musculature, an abdominal support may be beneficial when the patient assumes the erect position.

Unless the initial response is good, it is not likely that relief will be obtained from a medical regimen. In those with minimal obstruction, medical measures usually suffice. However, in those with marked obstruction, particularly if the early response to non-operative treatment is poor, surgery should be advised. Surgery should be performed early in those

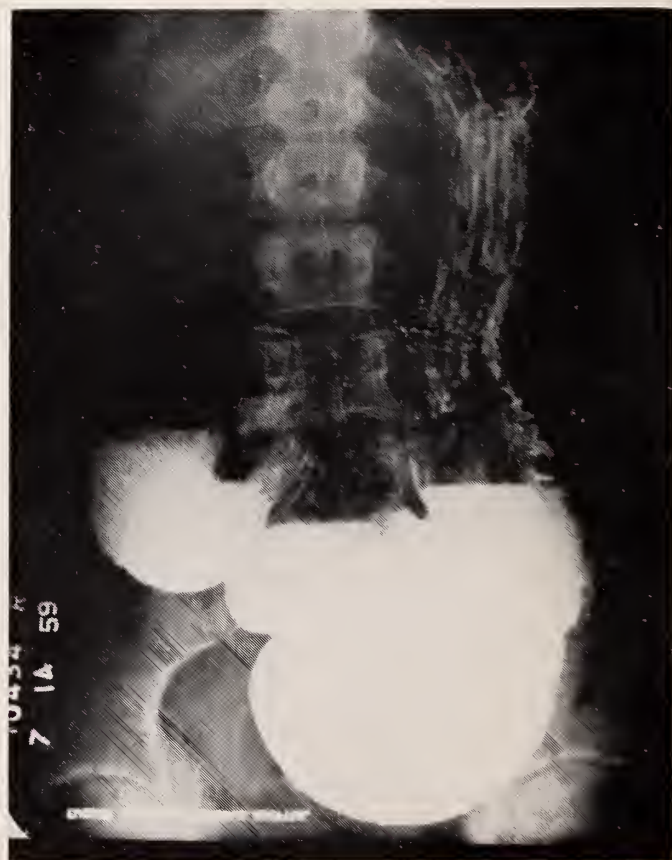


Figure 4

X-ray showing stasis in the duodenum and stomach.

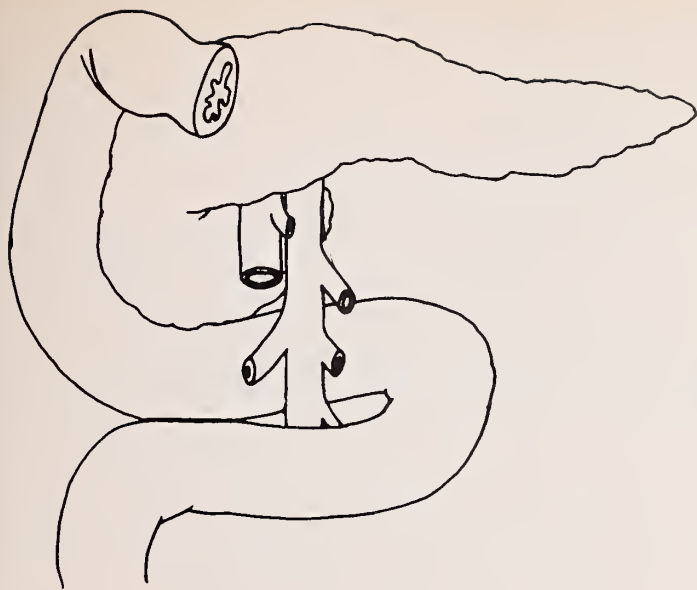


Figure 5

Drawing showing side-to-side duodenojejunostomy.

with persistent acute obstruction and in those with unrelenting chronic obstruction.

The usual surgical procedure consists of a side-to-side duodenojejunostomy which bypasses the obstruction by shunting the duodenal stream into the jejunum (Figure 5). This procedure is usually quite satisfactory and carries very little risk. The anastomosis should be located just proximal to the obstructed site in order to prevent difficulty from the blind loop between the anastomosis and the point of obstruction. At operation the diagnosis is confirmed by demonstrating the anatomic deformity, the dilated duodenum, and the relief of the obstruction by elevation of the mesenteric root.

Alternate Procedure

An alternate, and possibly superior, procedure consists of mobilizing the distal duodenum and displacing it downward and to the right as advised by Strong.⁹ This puts the duodenum in such a position that the mesenteric vessels no longer cross it and consequently cannot obstruct it (Figure 6). This seems to us to be a sound procedure but the reported experience with it is insufficient to allow final evaluation. It was used in one of our patients and it satisfactorily relieved the duodenum from the pressure of the root of the mesentery. However, because of a persistent narrowing at the point where the obstruction had been, a duodenojejunostomy was added. In another patient, not included in this series, with arteriomesenteric duodenal obstruction demonstrated radiologically and at surgery, the duodenum was resected because of an intrinsic obstructive diaphragm. This septum was complete except for a tiny two millimeter opening. It is necessary to exclude

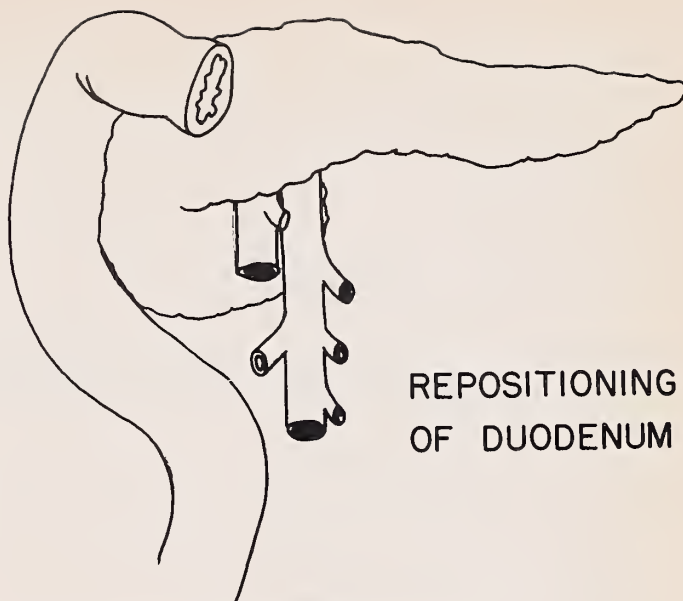


Figure 6

Drawing showing repositioning of duodenum.

such intrinsic obstructions before relying on duodenal repositioning alone. The observance of a free flow of air through the obstructed area, after instilling 200 to 300 cc. through a nasogastric tube as advised by Jones,² may be helpful for this purpose.

Summary

Twelve cases of arteriomesenteric duodenal obstruction have been presented, nine of which were considered primary and three secondary. Etiology, symptomatology, radiological diagnosis and treatment by medical and surgical means have been discussed. Prompt surgical intervention is advocated for those with marked obstruction who do not respond favorably to conservative measures.

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VERTIGO— DIFFERENTIAL DIAGNOSIS AND TREATMENT

B. W. Armstrong, M.D., *Charlotte, North Carolina*

- *Vertigo may be a symptom of disease in the ocular, labyrinthine, or central nervous system.*

DIZZINESS should not be confused with vertigo for they are not one and the same. I am impressed not by how many patients with dizziness have true vertigo but by how few. Unfortunately, the layman uses dizziness to describe a wide variety of sensations ranging from fainting to epilepsy and giddiness to true vertigo. Since a patient may have both dizziness and vertigo, we should guard against embracing their confusion.

Articles on vertigo are generally confined to one system or limited to a specific disease within that system. Thus, otologists write about labyrinthine vertigo, ophthalmologists about ocular vertigo, and neurosurgeons about central vertigo. The purpose of this presentation is to review briefly some of the characteristics of vertigo as related to disturbances in each of the three systems. Of necessity there will be omissions. Time and space do not permit this to assume the proportions of a monograph.

Definition

Vertigo is derived from the Latin word for turning whereas the word dizzy came from the Old English word, *dysig*, meaning "foolish" or "stupid." The terms dizziness and giddiness should be restricted to the sensation of unsteadiness *without* the sensation of motion. Patients with true vertigo will describe a sensation of motion. When a patient feels

that he himself is moving in space, he is said to have subjective vertigo; but when he senses that his environment is moving, the vertigo is said to be objective. Many patients experience a rotary sensation, but others describe falling, sinking, or wave-like motion. Dizziness without vertigo can be organic (hypoglycemia, cardiovascular), psychogenic (hysteria, fainting), or physiologic (motion sickness). These individuals have at most a sensation of unsteadiness or rocking but no spatial disorientation or ataxia. In contrast, the tabetic has unsteadiness of gait without dizziness or vertigo.

Anatomy and Physiology

Equilibrium depends upon muscle and joint sense (with or without conscious perception), active vision, and an intact labyrinth. These are coordinated by the central nervous system in order for the body to maintain positions in space, to regain these positions if disturbed, and to accomplish purposeful movements.

The vestibular labyrinth consists of three semicircular canals and the utricle. The utricle provides information about the position of the head, and the semicircular canals register motion, changes in the rate of motion, or change in direction. Laboratory investigations have shown the importance of labyrinthine reflexes in maintaining posture. When an animal is blindfolded to exclude ocular impulses, it is still able to maintain its head in normal relationship with the body if the labyrinths are intact. This reflex is maintained even after the cerebrum is removed.

From The Charlotte Eye, Ear and Throat Hospital, Charlotte, North Carolina.

Presented at the 109th Annual Session of the Medical Association of Georgia, May 7, 1963, Jekyll Island, Georgia.

The ocular righting reflexes, however, depend upon an intact cerebrum and are lost when the conscious centers are removed. In man, the ocular righting reflexes are more important than those of the labyrinth. Visual impulses also aid in orientation as to space and motion. Proprioceptors in the neck, trunk, and limbs provide the remaining information needed for normal orientation.

The staggering gait of a patient with vertigo may be considered to be a result of disturbed righting reflexes. When this disturbance is severe, he is unable to maintain his head in its normal relationship with his body and, consequently, falls.

The physiology of equilibrium may be briefly summarized as follows: Vision is of foremost importance in spatial orientation. Awareness of body position is accomplished by proprioceptors in the neck, trunk, and limbs. The vestibular apparatus aids in awareness of the position and movement of the head in space. Integration of these sensations by the cerebellum, posterior longitudinal bundle, vestibular and red nuclei, when interpreted by the cerebrum, results in orientation. Vertigo can be a symptom of disease in any one of the systems.

Ocular Vertigo

Although many patients with vertigo are referred to the ophthalmologists for examination of their eyes, the cause will rarely be found in the ocular mechanism. It is true that the ophthalmologist may report valuable information, such as the finding of choked disks when there is increased intracranial pressure, but we should not expect him to cure vertigo with new glasses. Some ophthalmologists even question the existence of true vertigo as a manifestation of disease in the visual system. The most commonly cited example of ocular vertigo is the fear of falling that is experienced when we look down from a great height. This sensation arises because the usual objects of fixation are absent, and it ceases if the eyes are closed. The onset of ocular muscle paralysis is accompanied by vertigo. Other types of ocular vertigo need not be considered here. Patients so seldom seek medical attention for ocular vertigo that it can almost be disregarded in the differential diagnosis. Severe vertiginous attacks are never of ocular origin.

Central Vertigo

Vertigo of central origin is not severe and usually has an insidious onset. Many patients seek medical attention because they have other symptoms of intracranial disease such as cranial nerve palsy, ataxia, or failing vision. The symptoms progress without clearly defined attacks of vertigo. There is a widespread impression that vertigo is a common symptom of

brain tumor. Experience has shown that this concept is not justified. True vertigo is seldom associated with cerebral lesions although it has been observed in patients who had a tumor of the frontal lobe. Vertigo is more commonly associated with neurologic disorders of the posterior fossa, particularly of the brain stem. It is neither episodic nor severe, however, except when associated with tumors or cysts of the fourth ventricle (Bruns's syndrome).

Vertigo is not an early symptom of cerebellar tumor and is seldom severe when present. Tumors of the cerebellopontine angle, including those of the acoustic nerve, may cause ataxia but *rarely* produce vertigo. Other lesions of the brain stem (encephalitis, multiple sclerosis, and vascular accidents) are more apt to cause vertigo.

Occlusion of the posterior-inferior cerebellar artery produces sudden, severe vertigo associated with loss of pain and temperature sensation in the face, paresis of the palate and vocal cord, and Horner's syndrome on the same side. There is also analgesia below the neck on the contralateral side as well as difficulty in speaking and swallowing. Vertigo is often the last symptom to disappear as these patients recover.

Vertigo may occur as a result of a severe head injury. It is most common after concussion and is frequently present after basilar fracture. The vertigo occurring after head injury is seldom spontaneous but usually is associated with postural changes.

A central lesion is probable if vertigo is accompanied by loss of consciousness, incoordination, sensory or motor disturbances, diplopia, persistent spontaneous nystagmus, blurred vision, or a visual field defect. Continuous "dizziness" may be psychogenic or due to intracranial disease.

Labyrinthine Vertigo

With rare exception all severe vertigo has its origin in the ear. There should be little difficulty in recognizing severe labyrinthine vertigo, and yet this condition is often confused with food poisoning, "biliousness," or syncope. The severe attack is characterized by its abrupt, apoplectic onset, the sensation of movement (generally rotational), nausea, vomiting, prostration, sweating, and usually nystagmus. The patient will often be found lying on the side of the normal ear because his vertigo is less intense in that position. He will resist movement for even the slightest motion will intensify his vertigo. The quick component of the nystagmus is directed toward the sound side, and there is past pointing toward the affected side. These patients are often so badly frightened that they fear death is at hand.

In contrast, labyrinthine vertigo may be so fleeting as to be hardly recognized by the patient as a

sensation of motion. Between these extremes there are many patients who experience vertiginous attacks of varying severity. It should be stressed, however, that periods of unconsciousness are not characteristic of peripheral disease, and when these occur, a central lesion must be suspected. Labyrinthine vertigo may be caused by local conditions in the external auditory canal (cerumen, foreign body) or acute closure of the eustachian tube (acute upper respiratory infection, aero-otitis). These conditions are self-limited, and local treatment is all that is needed.

A vascular accident involving the internal auditory artery is followed by an explosive attack of vertigo, nausea, vomiting, tinnitus, and unilateral deafness. Vertigo of short duration commonly follows injuries to the ear, particularly when there is traumatic rupture of the tympanic membrane or bleeding into the middle ear. In more severe injuries in which there may be damage to the vestibular apparatus the vertigo may persist for months.

Vertigo is a constant symptom in patients with labyrinthitis. Suppurative labyrinthitis occurs from the extension of an infection either in the middle ear and related structures or in the subarachnoid space. Labyrinthitis was more common in the days before chemical and antibiotic therapy, but it is still encountered as a complication of otitis media and mastoiditis, either acute or chronic. Vertigo is a prominent symptom and is accompanied by loss of hearing, nystagmus, and otorrhea. Any patient who complains of vertigo and who has a discharging ear must be presumed to have labyrinthitis until it is proved otherwise.

Meningitic labyrinthitis results from an extension of infection in the subarachnoid space as is observed in meningococcus and pneumococcus infections. The destruction of the labyrinth is rapid and is accompanied by vertigo and usually bilateral loss of hearing. The vertigo subsides slowly, persisting to some degree for many months. These patients have more difficulty when walking in the dark because then neither the ocular nor the vestibular mechanism is functioning, and they are dependent upon proprioception alone.

Toxic vertigo commonly accompanies systemic diseases and may be caused by certain drugs. Some of the agents producing toxic vertigo are streptomycin, tobacco, alcohol, quinine, and salicylates. *Most of the isolated attacks of true vertigo are on a toxic basis.*

There are many reports of vertigo resulting from hypersensitivity. It may occur as the only symptom or in association with other allergic manifestations. In some patients with Meniere's disease the attacks

have been controlled by eliminating the offending allergen.

Meniere's disease is diagnosed more frequently than it occurs. Nine out of ten patients who are referred to me with the diagnosis of Meniere's disease do not have it. Meniere described a syndrome consisting of tinnitus, progressive deafness, and recurrent attacks of vertigo. Only an otologist can make the diagnosis of Meniere's disease when one or more of these symptoms is not present.

The tinnitus of Meniere's disease is usually unilateral and may precede the other symptoms. The hearing loss is of the nerve type and grows worse with each attack. The typical attack comes without warning, and the patient is seized with a whirling sensation that may literally throw him to the ground. In association with the vertigo the patient has nausea, vomiting, prostration, a rapid pulse, and cold sweat—what Meniere called the “syncopal state.” Nystagmus is present, its quick component being toward the sound side. Attacks may be frequent or widely spaced. Between episodes there is no disequilibrium, hearing may improve, and tinnitus often diminishes.

The pathologic basis of Meniere's disease is an increase in the amount of endolymph with resulting dilation of the endolymphatic system. It has not been established whether this increase is due to the overproduction of endolymph or to failure of its normal absorption. It is not within the scope of this paper to discuss the controversy which has arisen over the etiology.

Postural vertigo is perhaps the most common type, and as the name implies, it appears only when certain positions of the head or body are assumed. The condition is generally benign and usually improves spontaneously in a matter of weeks or months.

Differential Diagnosis and Treatment

New antivertiginous drugs are being aggressively promoted by various companies with emphasis on symptomatic relief. Rational treatment should be correlated with the etiology and not limited to relief of a symptom. The antivertiginous drugs are of little value in the treatment of true vertigo.

Of greatest importance is a carefully recorded history. The examiner should be a good listener and encourage the patient to relate his experience in minute detail. “Dizziness” is often as difficult for the physician to evaluate as it is for the patient to describe. The complaint must be clearly and definitely understood. Seldom will there be any difficulty in the diagnosis of ocular vertigo. The following chart sets forth some of the points to be considered in differentiating central from labyrinthine vertigo.

This type of nystagmus deserves particular attention. Nystagmus, not unlike vertigo, may be of cen-

	CENTRAL	LABYRINTHINE
Onset	Gradual, continuous	Sudden, episodic
Intensity	Mild	Severe at onset
Duration	Varies — weeks, months, years	Minutes to days
Deafness	Rare	Common, often progressive
Tinnitus	Rare	Common, frequently worse during attacks; may improve between attacks
Nystagmus	Coarse, any type	Horizontal — rotary
Field	May change with gaze	Does not change
Vertical	Pathognomonic	Never
Past pointing	Pathognomonic when unilateral or crossed	To side of slow component
Falling	In direction of fast component; does not change with position	To side of slow component and changes with position of head
Unconsciousness	Occasionally	Never
Diplopia	Pathognomonic	Never
Neurologic examination	Positive	Negative
Otologic examination	Usually negative	Usually positive
Caloric test	Often normal	Usually hypoactive

tral, or ocular, or labyrinthine origin. Central nystagmus is long-standing and may be in any plane; other signs of central nervous system disorder are usually present. Ocular nystagmus is also of long duration; the movement is slower than in labyrinthine nystagmus, and the slow and quick components are poorly defined. It is associated with other evidence of ocular disease. Labyrinthine nystagmus is rhythmic and has well-defined quick and slow components. It is of short duration and generally accompanied by vertigo.

The caloric test provides valuable information since it initiates mild vertigo of controlled intensity and the resulting nystagmus can be observed. This test also gives us some insight as to the nature of the patient's complaint. When the caloric stimulation produces vertigo that is similar to but milder than his attacks, we can strongly suspect that he has labyrinthine disease. Observations of nystagmus and past pointing aid in confirmation. On the other hand, if the patient complains that the vertigo induced by minimal caloric stimulation is far more severe than his attacks, we can suspect that his difficulty may be functional.

The neurological examination should include the cranial nerves and tests for corneal anesthesia. If there are positive neurological signs (only about ten per cent of all vertigo is of central origin), the patient is referred to a neurologist or a neurosurgeon. Further tests are left to his discretion. When positive findings are limited to the ear and/or eighth nerve (otorrhea, impaired hearing, abnormal caloric response), the patient should be examined by an otologist. Hearing evaluation with pure tone and speech audiometry supplemented with tests for recruitment and discrimination may enable the otologist to establish the diagnosis. Patients with hyperactive caloric response and an otherwise normal

examination are referred to a psychiatrist if there are other suggestions of abnormal behavior.

Vertiginous patients in each category may be managed by the family physician in many instances. Of necessity some patients will come under the care of an ophthalmologist, neurologist, neurosurgeon, psychiatrist, or otologist for definitive treatment. Only the more common vestibular disorders will be considered here.

Postural Vertigo

Postural or positional vertigo may be of central or peripheral origin. In each type the patient has vertigo upon changing position or upon assuming a certain position. One may test for postural vertigo by putting the patient into various positions from standing to stooping and from sitting to supine. Turning his head to the right or left may demonstrate nystagmus (and vertigo) when the critical position is assumed. In the central type, nystagmus appears promptly when the head is placed in the appropriate position and continues steadily as long as the head remains in that position. Nystagmus may occur in more than one position and may change with the direction of the face. This type is found in patients with lesions in the vestibular pathways. Postural vertigo often follows severe head injuries.

In the peripheral type, which is much more common, nystagmus appears after a latent period of several seconds (up to ten) and disappears in ten to 30 seconds. These patients usually have no other signs of ear disease, and the neurological examination is normal. No definite cause will be found in many instances, but the circulatory system is apt to be at fault. Many patients with postural vertigo have vasomotor instability. Treatment is not very satisfactory although vasodilators and/or mild sedatives seem to relieve some patients. Reassurance and ex-

planation of the condition often do more good than any of the antivertiginous drugs. Fortunately, this is usually a benign, self-limited condition.

Toxic Vertigo

Toxic vertigo or vestibular neuronitis is the most common cause of a single, isolated attack of acute vertigo. The patients have nausea, vomiting, prostration, and nystagmus, but no tinnitus or alteration of hearing. The attack may accompany systemic disease or be caused by certain drugs. The patient should be given sedation and kept at rest. Intravenous benadryl is often effective. Atropine has long been used, but the dosage must be relatively large in order to be effective. At least 1/100 grain should be given subcutaneously. Many patients with toxic vertigo are mistakenly diagnosed as having Meniere's disease. The prognosis is good and no recurrence is to be expected.

Meniere's Disease

It should be emphasized again that Meniere's disease is characterized by recurrent attacks of vertigo as well as tinnitus and progressive loss of hearing. The treatment of Meniere's disease may be medical or surgical. Most of my patients respond to a low sodium diet and Hydrodiuril Ka, 25 milligrams per day.* This initiated at the first visit and modified at six-week intervals according to the response. In almost all instances there is relief from attacks, diminished tinnitus, and improvement in hearing within the first six-week period. Diet may be liberalized somewhat from time to time as the patient improves, and medication is then given on alternate days. By six months most patients are dismissed from treatment but cautioned that symptoms may return. When sedation and vasodilation are desired, I often give my patients what I have termed "vertigo mixture,"** teaspoons one 20 minutes a.c. and h.s. Smoking is definitely contraindicated in patients with Meniere's disease.

It should be emphasized that the results of treatment are extremely difficult to evaluate. Spontaneous remissions (and exacerbations) are common. Most patients can be controlled on medical treatment, but an occasional one will be a candidate for surgery. We have had only one patient for destructive labyrinthotomy in the last 13,000 surgical admissions to our institution.

Destructive labyrinthotomy and selective section of the eighth nerve both made their appearance over

fifty years ago. The choice of procedures is the choice between a major operation requiring several hours and a minor operation that takes about 30 minutes. Section of the eighth nerve involves a craniotomy, possible injury to the facial nerve, prolonged morbidity, and a significant mortality rate. Destructive labyrinthotomy can be done through the external auditory canal, the patient is able to leave the hospital in seven to ten days and is back at his work in three to four weeks. The facial nerve is not endangered, and there is virtually no risk to life. In spite of this contrast, intracranial nerve section grew in popularity and destructive labyrinthotomy did not. This can be explained by the fact that most physicians are still not familiar with the labyrinthotomy operation, and the persistent argument that selective nerve section preserves hearing. Actually most of the patients with uncontrolled Meniere's disease do not have hearing that is worth saving; furthermore, *useful* hearing is retained in less than 25 per cent of the patients subjected to nerve section. When the best interests of the patient are considered, destructive labyrinthotomy is to be preferred even though the residual hearing is sacrificed. Economically the procedure of choice is obvious.

Ultrasonic Energy

Ultrasonic energy applied to the vestibular labyrinth has been employed to control vertiginous attacks in patients with serviceable hearing and in those with bilateral Meniere's disease. This relatively new treatment shows considerable promise even though only about 50 per cent of the patients remain free of vertigo after a single exposure to ultrasound. Repeated exposures have controlled some of the patients with persistent attacks. The only real advantage of this procedure over destructive labyrinthotomy is the preservation of hearing. Unfortunately, hearing is not always preserved, and facial paralysis has not been infrequent. More experience with this form of treatment will unquestionably improve results and reduce complications.

True vertigo is not a functional disorder, but vertigo may be the underlying cause of a neurosis. Patients with Meniere's disease need reassurance, for in some instances their fear of an attack is more disabling than the attacks themselves. Some patients refuse to venture out alone even after their attacks have been controlled on a satisfactory medical program. Destructive labyrinthotomy may be preferable in selected cases to prolonged psychiatric care.

Vascular Accident

A vascular accident involving the internal auditory artery is followed by severe vertigo, nausea, vomiting, prostration, tinnitus, and unilateral deaf-

*This seems to be slightly superior to the Furstenberg program consisting of low sodium diet and large doses of ammonium chloride.

**Sodium phenobarbital 2., tincture belladonna 20., elixir ronicol qsad 240.

ness. Initial treatment is the same as for toxic vertigo. If these patients are seen during the acute phase, they should be hospitalized and anticoagulant therapy instituted as soon as hemorrhage is ruled out. Vasodilators should be given in effective doses (histamine injections are preferred by some clinicians). We have seen a number of patients regain normal hearing and equilibrium within a few weeks with this program of treatment. Perhaps they were going to have full recovery anyway, but the usual experience is permanent loss of hearing with gradual improvement in equilibrium over a period of months. Treatment must be prompt if hearing is to be salvaged. Many of these patients reach the otologist four to six weeks after the incident with a diagnosis of Meniere's disease and the inevitable vial of Dramamine tablets. By that time nothing can be done.

Labyrinthitis

Labyrinthitis must be suspected in vertiginous patients with a discharging ear. These patients should be sent to an otologist for evaluation. Mastoidectomy and labyrinthectomy will be necessary in a relatively small number of patients.

Motion Sickness

Motion sickness may be very severe and associated with nausea, vomiting, and prostration. Its similarity to the vertigo produced by lesions in the labyrinth is evident and leads us to believe that the vestibular apparatus is chiefly involved, although disturbance in the ocular mechanism is another factor. The absence of spatial disorientation and nystagmus in motion sickness serves to differentiate it from irritative lesions of the labyrinth.

Summary

The confusion about vertigo can be eliminated by careful attention to details and, in particular, by avoiding the use of Meniere's disease as a diagnostic wastebasket. Vertigo is disequilibrium and results from disturbed righting reflexes. Ocular vertigo, though common, is never severe and seldom causes the patient to seek medical attention. Vertigo from disorders of the central nervous system is usually mild in severity but tends to be prolonged. It is not an important symptom of brain tumor. With few exceptions all recurrent, severe vertigo is of labyrinthine origin.

1964 ATLANTA GRADUATE MEDICAL ASSEMBLY HAS EXCEPTIONAL PROGRAM IN STORE

As the program for the 1964 Atlanta Graduate Medical Assembly nears completion, it is evident that this will be a three-day medical meeting you cannot afford to miss. The meetings will be held at the Atlanta Biltmore Hotel on February 17, 18 and 19, 1964, with advance registration on Sunday, February 16. Following is a brief glimpse of the program:

Monday, February 17—*A DAY OF MEDICINE*

Dr. Jerome Conn will discuss the Medical Aspects of Diabetes. Dr. Alvan L. Barach will bring papers on Emphysema. Dr. Owen Wangenstein will give a discourse on Gastric Cooling and Freezing for Manifestations of Peptic Ulcer. Also invited are Doctors Belding H. Schribner and Joseph Edward Rall. Dr. Schribner will speak on Chronic Renal Failure and Dr. Rall will present papers on Laboratory Procedures in Diagnosis of Hyperparathyroidism and Thyroid Diseases.

Tuesday, February 18—*A DAY OF SURGERY*

On that day you will hear Dr. Harwell Wilson on Blunt Trauma to the Abdomen and Penetrating Wounds of the Abdomen. Dr. Champ Lyons will speak on Shock and Problems in Therapy of Carcinoma of the Breast. There will also be Dr. Weldon Bulloch of Los Angeles speaking on Breast Cancer and Colonic Polyps. Dr. James V. Rogers, Jr., of Emory Clinic, will give a paper on Mammography in Diagnosis of Carcinoma of the Breast. In addition, Dr. Richard K. Gilchrist will speak on Surgery of the Colon and Rectum in reference to Carcinoma, as well as participating in a round table discussion of Abdominal Surgery in the Aged. Tuesday afternoon will feature a large panel

discussion, with Dr. Champ Lyons as Moderator, on "Management of the Patient with Multiple Injuries."

Tuesday, February 18 — *A MORNING OF CARDIOLOGY*

Concurrent with the surgical program, a full morning of Cardiology will be sponsored by the Georgia Heart Association in the Ball Room of the Biltmore Hotel. Invited to speak are Doctors John Webster Kirkland of Mayo Clinic and Dr. Bernard Lown of Boston. A third speaker is to be invited.

Wednesday, February 19 — *A DAY OF OBSTETRICS, GYNECOLOGY AND PEDIATRICS*

Dr. Clarence David Davis and Dr. C. Lee Buxton, both of Yale University School of Medicine, will present a well planned program of Obstetrics and Gynecology. Each speaker will give two papers of 30 minutes each in length.

Dr. William Silverman of Columbia University and Dr. Robert Goode of the University of Minnesota have been invited to present the Pediatrics program. Dr. Silverman will speak on Problems of the Newborn; Dr. Goode on Rheumatoid Arthritis and other problems of disturbance of immunologic processes.

In the afternoon the Gynecologists, Obstetricians and Pediatricians will form a panel for a round table discussion of "Obstetrical Emergencies."

The Executive Committee has planned a very excellent program. Plan now to attend. February 17, 18 or 19, 1964 — attend one day or all three days.

BIOLOGICAL DOSIMETRY IN RADIATION INJURY

Alexander H. Woods, M.D., *Oklahoma City, Oklahoma*

■ *The sensitivity of the individual patient to ionizing radiation is unpredictable.*

IN MY FIRST ADDRESS to this meeting¹, I dwelt upon the potential hazards of promiscuous bone marrow hemografting in random cases of radiation injury. These hazards stem from the fact that the same marrow homograft which can be lifesaving after lethal exposure paradoxically increases mortality after low doses of radiation. The explanation for this arises from the immunological warfare which ensues when both graft and host are capable of reacting against each other. When only one is competent to react, i.e., when the host's immune apparatus is abolished by lethal X-ray, no conflict occurs and the graft is free to expand. The lesson to be learned here is to avoid the use of marrow homografts unless the patient has received enough whole-body radiation to reduce his chances for survival below about fifty per cent.

Difficult Concept

This concept is easily enough stated but it is almost impossible to follow in practice. When large amounts of radiation are encountered, the small lapel dosimeters of the type worn by many radiologists are useless. They are scaled for cumulative trickle doses of radiation and are hopelessly blackened by a major exposure. Calculation of the dose received by each individual must then be laboriously reached by considering the strength of the source, its distance, the duration of exposure, and what shielding might have been provided by intervening objects. From this, a rough estimate of dose can be obtained.

From the Departments of Microbiology and Medicine, University of Oklahoma School of Medicine, Oklahoma City, Oklahoma.

Presented at the 109th Annual Session of the Medical Association of Georgia, May 6, 1963, Jekyll Island, Georgia.

Although such dose estimates are important in planning therapy for any given patient, they neglect an equally important factor, namely, the sensitivity of that patient for ionizing radiation. It is almost axiomatic among physicians who use strong bone marrow depressants clinically that the response of any particular patient to a "standard" dose cannot be predicted. With nitrogen mustard, for example, the standard dose is 0.4 mg. per kg. This dose will produce a profound leukopenia lasting for weeks and preceded by pernicious vomiting and anorexia in one patient while the next may show absolutely no reaction whatever. This is accounted for by individual variation in sensitivity among patients.

We have very little information on what causes this variation. It is known that prior exposure to myelotoxic agents will increase sensitivity. Portal radiation will increase the toxicity of the antifolic acid agents, for instance. The existence of hemolytic anemia with its compensatory proliferation of the bone marrow may decrease sensitivity to myelotoxic agents. But in the vast body of clinically normal individuals no such ready explanation exists.

It is clear, then, that any calculation of injury from radiation must include both the factors of dosage and sensitivity. Since sensitivity cannot be determined without exposing the subject to radiation, the only practicable way of measuring both factors is by a system of biological dosimetry. What is needed is a method of quantitating radiation injury as reliable as in the body temperature in following the course of pneumonia, or perhaps even more so. If we can determine the degree of radiation injury by

such a method, then knowledge of the dose and of the sensitivity are not necessary: injury is a product of both.

It is surprising that no such system of biological dosimetry exists for radiation injury. The most common practice is to obtain serial blood counts and to equate these with the severity of nausea and vomiting, alopecia and other side effects of radiation. All these effects take time to reach their peaks; none are reliable before at least two weeks after exposure. By that time the die is cast and it is too late for such radical therapy as bone marrow grafting.

Better System

The need for a better system becomes more obvious all the time. The threat of nuclear warfare presents the possibility of uncounted radiation casualties requiring definitive handling with far less fanfare than has been accorded the dozen or so reactor accident victims. Man also proposes to fly through space, encountering two known and probably many unknown belts of high intensity radiation. In addition, the industrial use of nuclear energy is approaching and with it will inevitably come a rising tide of accidental exposures. Finally, we need such a system to measure the effect of radioprotective chemicals and the action of radiomimetic drugs. The virtues such a biological dosimeter should possess are outlined in Table I. I should like now to describe some of the possibilities which have been investigated, together with a system we have worked on in Oklahoma, and which we feel has many of the desired virtues.

TABLE I
Criteria For A Biological Dosimeter

- A. Reflect actual tissue injury.
- B. Measurable soon after the insult.
- C. Reflect injury to all tissues in known proportions.
- D. Precise and repeatable.
- E. Require a minimum of special skills and equipment.

Since measurements of serum transaminase and lactic dehydrogenase levels have become popular in clinical medicine, characteristic changes in serum enzyme levels have been sought in a wide variety of conditions. One of these has been radiation injury. Elevation of serum glutamic oxalacetic transaminase (SGOT) in irradiated rabbits was first reported in 1956², however, the increases were not very great and did not show a distinct correlation with dose. More recently 14 enzymes have been assayed in rabbit serum after exposure to a mid-lethal dose of radiation³. Of these, three (SGOT, lactic dehydrogenase and enolase) were significantly elevated twenty-four hours after exposure. Again, the increases, although significant, were small and would be easily masked by any other of the many afflictions

affecting serum enzyme levels. Serum aldolase was found increased in another study⁴, but this was not corroborated elsewhere³. Perhaps the right enzyme has not yet been tested, but at the moment it is safe to say that deviations in serum enzyme levels are not adequate dosimeters for radiation injury.

Radioiron Kinetics

Henessey and Huff⁵ first described the impaired incorporation of radioiron into erythrocytes in rats given whole-body irradiation. Since then a considerable number of workers have investigated various facets of radioiron metabolism after radiation. It is known that serum iron levels rise as erythrocyte incorporation falls, that iron turnover rates are depressed, and that the disappearance rate of radioiron from the plasma slows.

Our interest in radioiron kinetics was stimulated by the report that the plasma radioiron disappearance rate (FePD) slowed within two to three days of the administration of nitrogen mustard⁶. At the time, we were attempting to protect a group of cancer patients against very large doses of nitrogen mustard with bone marrow autografts and we needed a dosimeter. We were able to test the FePD system on fourteen of these patients, and the results encouraged us to test it in rabbits given whole-body irradiation.

Radioiron, injected into the blood, is destined almost entirely for the bone marrow under normal circumstances. Over 90 per cent of it will be found in the circulating red cells within two weeks. When the marrow is injured, maturation of preformed erythrocyte precursors continues until the supply is exhausted. No new ones can be formed since radiation injury produces a mitotic arrest. This causes iron to stagnate in the blood; less and less is removed in the damaged marrow. As an index of this, the plasma radioiron disappearance and rate (FePD) decreases from a normal figure of about 70 minutes to values over 500 minutes, depending upon the extent of bone marrow injury. We have found that the maximum slowing of iron removal takes place about three days after injury in man and two days after injury in rabbits. This early maximum was encouraging for use of the FePD as a dosimeter; one of the criteria set up was for measurement soon after injury.

Degree of Injury

The next point to investigate was whether the FePD bore any proportionality to the degree of injury. In our patients given nitrogen mustard, we attempted to show a straight line relationship between the third day FePD value and the dose of mustard given. A straight line did, in fact, exist, but only with very high doses. At low doses there was no

correlation and this we attributed to the effect of individual variation in sensitivity. At higher doses, this variation would be obliterated beneath the overwhelming weight of the insults.

In rabbits, a similar linear relationship was again observed, and when different groups of rabbits were compared we were able to pick out a precise value of the second day FePD which described the mid-lethal or LD50 degree of injury. Interestingly, this mid-lethal value of 440 minutes occurred at different radiation dose levels for different groups of rabbits. Some groups reached it after only 400 r of X-ray, others required as much as 975 r. This was a reflection of variation in sensitivity, but this time it occurred between entire groups of 20 - 30 rabbits instead of on an individual basis. The question immediately arose as to what could produce this variation of over 100 per cent in radiation sensitivity, and could the answer be applied to man. If it could, we would have, at the same time, an answer for the riddle of varying sensitivity and the means for increasing radioresistance. Should the same factor of

over 100 per cent increase in resistance be observed in man as in rabbits, the implications in reducing morbidity during nuclear warfare were impressive, to say the least.

This point is the subject of current investigations. We are also striving to standardize the FePD technique so that it will become a useful clinical tool in all forms of the bone marrow injury. At the last, we believe these results point the way toward the desired biological dosimeter.

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RECIPIENT OF 1963 MAG DISTINGUISHED SERVICE AWARD EXPRESSES APPRECIATION

G. Lombard Kelly, M.D. of Augusta recently expressed his appreciation for receipt of the Medical Association of Georgia's 1963 Distinguished Service Award in a letter addressed to John T. Mauldin, M.D., Secretary of the Association. The award is presented for distinguished and meritorious service which reflects honor and credit to the Association.

Varied Fields

A former Dean and President of the Medical College of Georgia, Augusta, Dr. Kelly's services and contributions have been felt in many fields of medicine. He has served as Chairman of the Council of Medical Service of the American Medical Association and was a guiding force in establishing and developing the Student American Medical Association. Dr. Kelly was associated with Dr. George Papanicolaou, whose research involving the Pap Smear was partially motivated by Dr. Kelly's research studies on the reproductive tract of the guinea pig. His various books on the subject of sex, written for both the physician and the lay reader, have been translated into many languages. His book, *Sex Manual*, has had a printing of close to one million copies. As Dean of the Medical College, he saw, in the closing years of his administration, his dream of a vast medical center, in the construction of Eugene Talmadge Memorial Hospital, come true.

Now in his 73rd year, Dr. Kelly has devoted more

than three decades of his life to medical teaching and administration. Following is his letter of appreciation to the members of the Medical Association of Georgia:

July 21, 1963

John T. Mauldin, M.D., Secretary
Medical Association of Georgia
938 Peachtree Street, N. E.
Atlanta 9, Georgia

My dear Doctor Mauldin:

I wish to acknowledge with sincere thanks receipt of your notification of my selection for 1963 for the Distinguished Service Award by the Medical Association of Georgia and also, more recently, for the beautiful and tasteful framed medal with ribbon and engraved statement of presentation below it.

I wish to express my deep thanks and appreciation to the Committee entrusted with awards made by the Association and I trust this expression of appreciation may be conveyed to the members of the Committee.

The framed physical evidence of the sentiment that prompted the Award will be cherished always by my Father and me.

With assurance of my best wishes and kindest regards, I remain,

Very sincerely yours,
G. Lombard Kelly, M.D.

J. M. A. GEORGIA

DIAGNOSIS AND TREATMENT OF CARCINOMA OF THE PROSTATE FROM A GP VIEWPOINT

Samuel L. Raines, M.D., *Memphis, Tennessee*

- ***Early digital detection by the family physician constitutes the cornerstone for successful treatment.***

IT IS A PLEASURE and privilege to be invited to talk to this association upon a subject that is gaining in importance to us all. It is particularly appropriate, I believe, that the subject of carcinoma of the prostate be presented to a group in which the general practitioner predominates, for it is upon him more than anyone else that the early detection and diagnosis of this important disease falls. I wish to dwell more upon the early diagnosis and treatment than anything else, because here lies our hope of improving our results. It is probable that I have nothing very new or startling to present to you, but I am very anxious to review some of the facts which are already familiar to you and emphasize them as clearly as possible.

Life Span Increased

The average span of life in our population has steadily increased so that there are more people in the upper ages and, therefore, more such cancers are encountered than ever before. In the male, next to carcinoma of the stomach, that of the prostate occurs most often. The treatment of this tumor was revolutionized by Huggins in the early '40's, his pioneer work showing the influence of the female hormone upon the course of this disease. Many of us have seen tumors, which without being treated, grow and spread so slowly that ten to 15 years may pass before the patient succumbs. We have seen dramatic regression of symptoms of pain and metastatic spread by the use of estrogens and orchiectomy. On the

other hand, we have seen some of our patients lose strength rapidly and die quickly from this disease. The puzzle of it is, how to tell in any individual case whether this will be a fast growing or slow growing cancer. For that reason, we must undertake to treat each patient by every means possible to either wipe out the tumor or retard its progress.

Early Recognition and Diagnosis

As in cancer everywhere, our first and chief concern is to develop our capacity for early recognition and diagnosis. Here the original examining physician constitutes the most important screening mechanism we have. It is to this group that we direct our plea for routine rectal examination, a careful and suspicious attitude toward any unusual finding, especially a nodule, and most especially a *unilateral* one. These measures, coupled with energy and tenacity on the part of the physician, spell a high average of early recognition of carcinoma of the prostate.

It is necessary that the diagnosis of carcinoma of the prostate be made early and that it be accurate. It must be made early so that we have a better chance of complete removal and, therefore, a higher percentage of cures. It must be accurate so that mistakes and unnecessary surgery may be avoided.

Examining Finger

How do we establish an early diagnosis of carcinoma of the prostate? Let me repeat over and over to you that the examining finger in the rectum is the first and foremost way of detecting it, and some

Presented at the 109th Annual Session of the Medical Association of Georgia, May 7, 1963, Jekyll Island, Georgia.

rather remarkable statistics were discovered at the Walter Reed Hospital during wartime, when widespread routine rectal examinations were made on a large volume of officers and patients coming through there. I do not propose to present a large battery of figures and statistics in this brief talk, but these findings are so significant that I wish to emphasize them to you. It has been generally agreed by most everyone that when a patient with carcinoma of the prostate presents himself to the urologist or anyone else, with signs and symptoms of bladder neck obstruction and urinary retention, then about 95 per cent of those are inoperable and only five per cent operable. On the other hand, they did routine rectals on every patient among the thousands that came through the Walter Reed Hospital, and every nodule was carefully followed and biopsied. When the figures were in, it was found that about 55 per cent among this group who had carcinoma were early enough for total excision and in a much more favorable position for cure. This shows that by early discovery of the nodule and prompt biopsy, the group that could be classified favorably for a cure was eleven times as great as those who came in the late stages with bladder neck obstruction. This, I submit, is a most important and significant finding and probably the most important thing I will be able to present to you.

Fifty Per Cent Malignancy

It is also of interest to note that Jewett and others have stated that of the hard, unilateral nodules detected by rectal examination and carried on to biopsy and positive diagnosis, approximately 50 per cent of them are proven to be malignant. Therefore, it is urged most strongly that, once you find a nodule on a prostate, especially if it is unilateral, but even if it is bilateral, you exclude other common causes and if necessary, by all means have a biopsy taken for definite microscopic diagnosis.

Best Methods

What are the best methods of securing a biopsy of a nodule in the prostate?

First, the needle or punch biopsy, which may be perineal or transrectal. This method has some advantages and disadvantages, just as all of the methods do. The chief objection to the needle or punch biopsy is that the material secured is very small, and it is difficult to make a diagnosis from it. Indeed, unless one has a pathologist who is exceptionally skilled and experienced in examining these small particles of tissue, it is impossible to place reliance upon it. And don't forget, a pretty large operation of great importance to this patient's life

is to be based upon your diagnosis. Occasionally, though not very often, the punch diagnosis has been judged positive or negative and the cut section of the specimen removed has shown the opposite, and, of course, this is sometimes tragic and embarrassing to all. More recently, some larger needles, or trocars, have been utilized and the pieces obtained, therefore, are much more satisfactory and this method, with skill and a good pathologist, has come into greater use. Another point in favor of the needle or punch biopsy is that some patients will submit to it who would possibly refuse a more extensive procedure and, of course, a little tissue is better than none at all.

Resection Method

Second, the transurethral resection method. Tissue can be taken transurethrally and with the finger in the rectum pressing upward on the prostatic nodule, it is possible to get the loop well down to the posterior capsule, and usually one is able to get a satisfactory biopsy this way. On the other hand, from personal experience and when I was reasonably sure there was tumor present, I have completely failed to reach the tissue I wished, and a negative report has been returned when all else pointed to its being positive, and later events proved this to be correct. Therefore, a positive report from a transurethral biopsy is significant, but a negative report must be viewed with some skepticism, especially if the nodule is small. As we all know, most carcinomas of the prostate begin in the posterior lobe, and this increases the difficulty of reaching it with a transurethral biopsy.

Perineal Biopsy

Third, open perineal biopsy. This is the surest and possibly the best protection for both doctor and patient. To be sure, it is an operative procedure and some patients will object, but when one discusses the matter of safety and the importance of the diagnosis, most of our patients will gladly cooperate in this important step. If the frozen section is positive, total prostatectomy may be carried out immediately. If the frozen section examination is equivocal, then the wound can be closed and the completely stained section report awaited. If it is positive, the wound may be re-opened and prostatectomy done without having to make a new incision. Should one care to remove the prostate retropubically, then the dissection from above is made much easier because of the preliminary freeing of the under surface of the prostate.

Fourth, cytology. This method is simply not accurate enough to be of significance at this time, since it was shown by the Memorial Hospital some years ago that only two patients out of 1,738 examined showed carcinoma by this method that were not already suspected in some other way.

Fifth, acid phosphatase, serum and prostatic. This is too variable to be of great significance; although, if the value is excessively high, it would indicate further confirmatory tests.

Disease Entities

Since it is the duty and responsibility of the general practitioner to discover and classify and rule out carcinoma in all nodules and hard areas in the prostate, it is appropriate, I believe, to ask just what disease entities should be considered in the differential diagnosis. Here, again, I emphasize that the problem is in discovering the early lesion and not the late one. In the large, hard, fixed prostate I believe most of us could readily identify the carcinomatous process. In the nodules and other hard areas on the prostate, we must consider for differential diagnosis some of the following: Inflammation of the prostate is no doubt the most common cause of some firmness in the prostate, but it rarely gives one the hardness of carcinoma and usually is preceded by a history of prostatitis, some tenderness over the gland, and usually the finding of pyuria, white cells in the massaged secretion or other evidences of inflammation. Prostatic calculi can form a hard nodule in a prostate, and of course this is usually a complication of inflammation, and here X-ray would quickly help in establishing the diagnosis. Tuberculosis and syphilis and other rarer diseases must sometimes be considered. Some have tried to establish a degree of elevation of the edges of the prostate and make some correlation between that and carcinoma, but my advice to you is to carefully investigate and biopsy every nodule you find in the prostate, unless you have a strong reason to believe it is one of the above entities and not carcinoma. Let me further suggest to you that if you must guess or err, please err on the side of an aggressive attitude and prompt biopsy rather than one of ultraconservatism and inactivity.

Early Treatment

Now, let me discuss with you for a little while the treatment of early carcinoma of the prostate, not necessarily because you will be operating on these patients, but because he is usually your patient and has been referred to a urologist, and the patient will come to you for advice and, indeed, much of the follow-up treatment would be in your hands, and it is well for you to understand some of the things we would commonly attempt to do.

First of all, the treatment of carcinoma of the prostate would depend somewhat upon the age of the patient, and it is generally felt that a person under 75 years of age has enough life expectancy to justify some major surgery on this condition. On the other hand, in a patient over 75 his life ex-

pectancy hardly justifies the morbidity and risk involved. This is on the assumption that most patients with carcinoma of the prostate will live about five years whether you treat them conservatively or surgically.

Our preference is for a total prostatectomy and seminal vesiculectomy in early carcinoma of the prostate, since complete removal is still the best treatment for any cancer. This may be done perineally or retropubically or by a combination of the two approaches, depending upon the training and skill of the operator. There are those who prefer the conservative approach, using a transurethral resection to establish a satisfactory channel, plus the use of hormones, with or without bilateral orchiectomy.

When is the best time to perform orchiectomy? There is a difference of opinion on this subject since some feel it should be reserved for the late symptoms when some recession in the pain or morbidity could be accomplished by orchiectomy. There are others who feel that by doing it early and promptly, the onset of late symptoms can be postponed. It has seemed to us that the majority of opinion favors early use of both hormones and orchiectomy.

Late Carcinoma

And now, for a few comments on the treatment of late carcinoma of the prostate.

First, we must maintain the channel through the prostatic urethra so that the urine may drain satisfactorily. This is usually accomplished by a transurethral section, even if it has to be repeated several times. As you no doubt know, the carcinomatous prostate bleeds much less and cuts much more exactly and firmly than the benign one; therefore, a transurethral resection on a carcinoma is relatively easier than one on a benign gland. When this method seems inadequate, then we must at times do a cystotomy placing a tube through the abdominal wall, or if the prostate sloughs and bleeds too severely, then a prostatectomy must be done to control this condition. We have recently diverted the urine through an ileal loop and given the prostate and bladder a very much larger radiation therapy dose than is possible if the urine must go through the bladder. In several of these the results have been most favorable so far.

Next, we utilize estrogens and bilateral orchiectomy early. In this connection, if it appears our results are not satisfactory, the dosage of the estrogens can be greatly increased and, indeed, it has occasionally been found that the larger doses are better tolerated by the gastro-intestinal tract than the smaller doses.

Thirdly, the use of steroids has at times given these patients at least a temporary boost and a

CARCINOMA OF PROSTATE / Raines

period of well-being, which is most welcome to these sufferers.

Fourthly, adrenalectomy, hypophysectomy and radiation of the pituitary are mentioned merely to say that they have been tried and found wanting, and in our opinion they seem of doubtful value.

Choice and Response

Fifth, which estrogens should we use, and how prompt is the response to the use of estrogens and orchiectomy? We have no special favorite among the estrogens, and you are familiar with TACE, Stilbesterol and others. There are various intramuscular preparations available which are fairly long acting and very satisfactory. Our usual choice is Estradurin. It has been shown in some of our late malignancies, when pain and other symptoms are present, that the response to the estrogen and orchiectomy is dramatic and prompt, sometimes within just a few days; and therefore we have a right to feel that even in the early cases the favorable effect upon the body is just as prompt.

Six, chemicals. The use of chemotherapy is only in its infancy in the treatment of carcinoma everywhere in the body, but investigations seem to indicate that they promise a possible future that might be of great importance in treating this condition. In

addition, gold, chromium and other metals have been utilized and it has shown that the tumor in its original site can be destroyed by these elements. Unfortunately, metastases cannot always be reached and treated by this method and thus, it has its limitations.

Results

Now, briefly, what are the results of the various general plans of treatment of carcinoma of the prostate? As we have indicated above, there are those of the conservation school and those of the surgical school. In general, and without attempting to quote figures or dispute anyone, I would like to state that it appears that conservative management, consisting of transurethral resection, followed by palliation, using hormones and orchiectomy, shows survival rates up to five years equally as good as those who have had surgical removal. On the other hand, the radical and complete removal, plus the use of estrogens and orchiectomy, shows many more patients living and well ten years or more, than in the group handled conservatively. It is our conclusion that no method is better than total excision whenever this is possible and when the age and general condition of the patient justify it. It is, therefore, our plea that all of you concentrate upon early diagnosis, using routine rectals and prompt biopsy to establish this diagnosis early and thus permit prompt and radical removal.

University of Tennessee College of Medicine

MISLEADING PAMPHLET A BLATANT APPEAL TO EMOTIONALISM

A GROUP of physicians, under the name of "Physicians Committee for Health Care for the Aged Through Social Security," has sent members of Congress a pamphlet in support of H. R. 3920 and S. 880. This pamphlet, which seeks to influence members of Congress and the public on this legislation, contains misleading and inaccurate statements as well as assumptions unsupported by evidence.

Deceptive Title

The very title of the pamphlet is deceptive — "Why Physicians Support Hospital Insurance for the Aged Through Social Security." Members of Congress are sufficiently well informed to realize that only a few physicians support this legislation. But the title of the pamphlet could well deceive many people not so well informed into believing that the medical profession favors the proposal. It seems reasonable to assume that these words were carefully chosen in an attempt to

conceal the fact that out of more than 271,000 physicians in the country only 40 have expressed a willingness to be identified with this committee or to become signatories to a pamphlet of this kind.

The opening statement that "physicians have long been concerned because the elderly of our nation live in fear of the catastrophic costs of hospitalization" is a blatant appeal to emotionalism.

Physicians, more than anyone else except the aged themselves, know, or should know, that the prospect of being hospitalized is of less concern to the majority of older Americans than other aspects of living during retirement years. This is not to say they do not reflect upon the possible economic consequences of illness. Indeed they do, as evidenced by the fact that some 60 per cent of the population over 65 now has health insurance protection. Nearly ten million aged have health insurance, a half million have incomes of \$10,000 a year or more, more than two million receive

medical care under the Old Age Assistance program, and more than 120,000 a month avail themselves of the benefits of the Kerr-Mills Law. These facts alone reveal the absurdity of the portrait of the aged as a 17½ million member group of citizens perpetually haunted by the fear of the cost of hospitalization — not hospitalization itself, but its cost.

Information Solicitation

The American Medical Association and state and county medical societies have for several years sought evidence of individuals in this country being denied medical care solely because they can't pay for it. The AMA has twice asked members of Congress for any information of cases of this kind so that the needed medical care can be provided. Hundreds of county societies have advertised in newspapers soliciting such information and pledging help to anyone who needs it. Only a few cases have been brought to the attention of the profession.

A subsequent statement in this pamphlet verges on the unbelievable, namely that "physicians know that because of this fear (of hospital costs), many older people who need hospital care do not get it at all or get it too late."

If these 40 physicians, most of whom are associated with hospitals, clinics or health care plans, can say unequivocally that they know that many older people are not receiving needed hospital care solely because of financial fears, they must have concrete evidence of it, including circumstances and names. And if they have, it is incredible that they do not provide these people with the hospitalization they need or call the cases to the attention of others who will.

Members of this committee, in a number of instances such as these, have made unqualified statements without benefit of supporting evidence, or have utilized the device of selective statistics to reinforce their arguments.

Indicated

Health insurance and prepayment plans are indicated as inadequate or too costly for the elderly. The physicians who attached their names to this pamphlet, however, offer no standard for measuring adequacy and, if they have one, do not apply it against policies the aged are buying. The fact that some ten million of the aged have purchased health insurance would seem to demolish the argument that it is too costly.

The Kerr-Mills Act is dismissed as having "clearly failed to meet the needs of any but a very few of the very neediest aged." Other erroneous statements made about Kerr-Mills include:

1. "Less than seven out of every 1,000 aged people in the nation (in the spring of 1963) were receiving any assistance under MAA."

2. Kerr-Mills funds "are used in large part to subsidize existing state relief programs."

3. "Benefits are generally meager, spotty, and often uncertain. In many instances, limited state tax resources and high cost of good care have resulted in the use of facilities that endanger health and safety."

4. Administrative costs "have run as high as 124 per cent of the benefits in one state (Kentucky)."

5. "The relief that is available is given only after resources are used up and incomes are permanently reduced."

6. "Relatives with modest incomes may even be taken to court and forced to give aid."

Whoever wrote this pamphlet evidently avoided an examination of the Kerr-Mills record. This record, which is available from the Department of Health, Education and Welfare, is not one of largely subsidizing state relief programs or helping only "very few of the very neediest aged."

Only about 30 per cent of MAA recipients have been transfers from other programs, mainly Old Age Assistance. Nevertheless, OAA medical care payments have steadily increased since the Kerr-Mills Act became effective, and in addition MAA benefits as of May, 1963, were running at the rate of nearly \$350 million a year. The statistic that only seven out of 1,000 aged were receiving MAA assistance is deceiving. The fact is that by the spring of 1963, about seven in 1,000 were being helped *every month*.

Facts Obvious

It would seem obvious that most of the very neediest aged were still receiving medical care through OAA now as in the past and that the bulk of MAA expenditures (nearly \$29 million in May, 1963) are being paid for assistance to aged who are not on OAA rolls.

Furthermore, since a majority of the aged live in states which have implemented Kerr-Mills, a figure of seven out of 1,000 may well be a measure of the need for such an assistance program for the aged rather than an indication of failure as this pamphlet suggests.

Charge Not Documented

States with Kerr-Mills programs may be interested in the charge that they are administering them in some instances in a manner actually endangering the health and safety of the aged. This charge, of course, is not documented.

So far as Kentucky is concerned, elementary principles of fair play should dictate that this state's experience with Kerr-Mills administrative costs should be examined on the basis of current facts. Administrative costs in Kentucky now are reported to be running under five per cent.

Statement Untrue

The statement is simply not true that Kerr-Mills assistance is available "only after resources are used up and incomes are permanently reduced." All the state laws are designed to conserve the recipient's minimum resources, and no state requires permanent reduction of income. Resource and income limits are measures of eligibility, intended to assure that tax funds will not be dissipated on those able to finance their own health care. The aged who are eligible suffer no loss of income from the operation of the Kerr-Mills program. On the contrary, their incomes are preserved, not reduced. A number of states, as they have gained experience with Kerr-Mills programs, have increased the resource and income limits and thus brought benefits to greater numbers of the aged.

The charge that relatives with "modest incomes" may be taken to court is patently a scare technique. Fewer than half the states with Kerr-Mills programs functioning in January this year had relative responsibility laws. None of these laws is designed to force those with "modest incomes" to contribute to support of relatives. Their own incomes and financial obligations are taken into consideration in determining their ability to assist. It is interesting that the pamphlet says relatives "may" be taken into court, not that they are. Consequently, it

MISLEADING PAMPHLET / Continued

must be concluded that the sentence is intended to frighten the uninformed.

The pamphlet describes the hospitalization program proposed in H. R. 3920 and S. 880 as insurance, with benefits to be paid as "a matter of earned right." Everyone familiar with the Social Security law knows that current taxes pay current benefits and that an individual's payroll taxes are not set aside for his future benefit. The Internal Revenue Service considers social security benefits as gifts from one group of taxpayers to another and are therefore not taxable. The "earned right" contention implies a contract between recipient and the government. There are, of course, obvious flaws in such reasoning. More than 17 million aged who would be entitled to benefit of this legislation immediately, for example, could not claim an earned right, since they would have paid nothing under the program. Furthermore, these 17 million would comprise the majority of eligibles for many years to come. More important to this argument, however, is the implication that Congress would be foreclosed from amending the law, once enacted, to reduce benefits. This, of course, is nonsense. Moreover, the solvency of the Social Security System rests, not on actuarial insurance principles, but on the power of Congress to levy taxes and the further power of Congress to reduce benefits as an alternative to increasing taxes if the program runs into serious financial trouble.

The writer of the pamphlet has in other respects been careless with facts, stating that this legislation would "permit voluntary organizations, such as Blue Cross, to perform certain administrative functions," would "utilize state agencies in planning, in determination of eligibility of providers of services and in consultation to the providers" and would guarantee free choice of physician and hospital.

Private organizations could not on their own initiative step in and perform administrative functions. They could enter the picture only if invited by providers of services and then only by agreement with the Secretary of Health, Education and Welfare on his terms. State agencies could become involved in all the functions mentioned only on the secretary's request.

Free choice would not be guaranteed to all the aged eligible for benefits, despite the language of the legislation. Services would be available only in those institutions participating in the program under agreement with H.E.W. Free choice, as used in this pamphlet and in the legislation, could be guaranteed to the recipient only if every hospital and every nursing home and every nursing home agency was forced to participate.

One final observation should be made. The Physicians Committee for Health Care for the Aged Through Social Security has, by submitting this pamphlet to members of Congress, become directly engaged as an organization in lobbying. Has it complied with the law and registered as a lobbyist?

SYMPOSIUM IN ATLANTA TO BEGIN NEW YEAR FOR GEORGIA DOCTORS

"Clinical Emergencies" will be the major topic of discussion at the Medical Symposium scheduled for Thursday, January 23, 1964, at the Riviera Motel, Atlanta. Sponsored by the Georgia Academy of General Practice and Geigy Pharmaceuticals, the program will host an illustrious slate of guest speakers. Program Moderator for the entire session, which will convene at 1:30 p.m. and close at 4:30 p.m., will be Edward H. Rynearson, M.D. of the Mayo Clinic, Rochester, Minnesota. Appearing as speakers and panel members will be Edward S. Orgain, M.D. of Durham, North Carolina, who will discuss "Cardiac Emergencies;" Thomas H. McGavack, M.D., Martinsburg, West Virginia, speak-

ing on "Metabolic Emergencies;" and William F. Sheeley, M.D., Washington, D.C., whose topic will be "Psychiatric Emergencies."

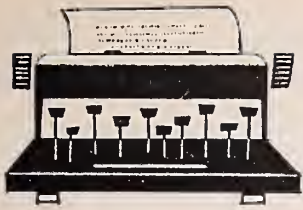
Registration will be from 12:00 noon to 3:00 p.m. in the Mediterranean Ballroom of the motel. The symposium has been accepted for four (4) hours of Category 1 credit for members of the American Academy of General Practice. A reception-cocktail party, sponsored by Geigy, will be held after the meeting for all attending physicians and their wives.

Further information concerning the symposium may be obtained by writing GAGP President, Albert L. Morris, M.D., Fairburn, Georgia.

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America's Number One Epidemic

APECULIARLY American disease, so statistics tell us, is our national and apparently insatiable desire to destroy ourselves in automobile accidents.

As crash deaths and injuries mount, the obvious solution to this mania for self destruction lies in two areas—the driver of the automobile and the machine itself.

Imperative Education

Numerous programs, on national and local levels, are aimed continually at driver education—"Slow down and live" or "The life you save may be your own." It is obvious that driver training and education are imperatives, but as in any attempt to modify human attitudes, the progress is slow. Automobile accident fatalities continue to mount in spite of official and voluntary efforts to turn the tide. We can only speculate at how high the statistics would soar if there were no driver education programs or accident prevention safety campaigns to hold deaths in check.



The other basic approach—concurrent with attempts to solve the human problem—is to the great big shiny machine the peculiarly motivated American uses to hurl himself down highways and byways.

The Measures

What can be done to the automobile itself to make it optimally safe? What can be done through research and manufacturing skill to protect the driver, perhaps against himself, while others are working on his aptitudes and attitudes?

Four Georgia groups, in cooperation with Cornell University, are working on the answers to these questions. The Medical Association of Georgia, the Georgia State Patrol and the Georgia Hospital Association are the participating agencies. The Georgia Department of Public Health through its Housing Hy-

giene and Accident Prevention Service is serving as medical coordinator of the project.

Known as Automotive Crash Injury Research (A. C. I. R.) the field project just getting underway in Georgia will last two years (See *J.M.A.G.* September, 1963). During these two years, a concerted effort will be made by the cooperating agencies to report on all injury-producing accidents in Georgia involving passenger cars of the last four year models. The two year study will be conducted in four six-month periods beginning in Athens, followed by Albany, Reidsville and Canton. These are State Patrol troop area headquarters and serve as field coordination points for the four field studies; only accidents investigated by the State Patrol are within the scope of the study.

The A. C. I. R. project in Georgia, to determine how automotive design can contribute to passenger safety, will succeed or fail based on reports supplied by Georgia physicians and State Troopers.

In Detail

The information from the State Patrol covers in detail the conditions surrounding the accident itself: road design, type of road, surface conditions, number of vehicles involved, estimated speeds, details of external damage to the involved vehicles, objects struck by occupants. Additional information is supplied by State Troopers on interior damage to the automobile, and photographs, when needed, will supplement the written report.

Step two in the chain of field research is the completion of the A. C. I. R. medical report form by the physician attending the accident victim. The form, which takes less than five minutes to complete, is given by the investigating patrolmen to the attending doctor or to the emergency room supervisor of the hospital to which the accident victim is removed. A separate medical report is submitted for each injured person; stamped self-addressed envelopes are supplied to physicians to simplify submission of reports.

Coordination of reports from troopers and phy-

EDITORIALS / Continued

sicians is done in Atlanta by the State Health Department. The package of field data is transmitted to Cornell University for intensive study. The physicians' reports are considered privileged medical information.

Will Not Disappear

Information from previous A. C. I. R. studies did not disappear into a statistical lost forest. Many life saving features on the automobiles of 1964 came

from these and similar studies. Strengthened door locks, recessed steering wheel posts, padded dash boards and sun visors and, of course, safety belts—now required by law on new cars in Georgia—are life saving devices that might not be on our new cars without field research.

The need is obvious; the goal important and dramatic. For these reasons the Medical Association of Georgia commends and supports the Automotive Crash Injury Research program.

Medicine And Religion

THE SEASON OF CHRISTMAS is a season enjoyed by all because it is a time when the majority of mankind is deeply concerned with his fellow man.

As physicians, our dedication of life is to serve our patient and to do all in our power to return to that patient total health. The new program under the direction of the Department of Medicine and Religion of the American Medical Association has as its sole purpose to assist the physician in the total care and treatment of the patient.

The state committee on medicine and religion of the Medical Association of Georgia met in Novem-

ber to make plans for carrying out the program through the various component parts of Georgia medicine. There are times when the clergy can be of assistance to the physician, not only to the patient but oftentimes to the family of the patient.

In this season when concern and compassion abound, it is well that we begin our program of the relationship of physician and clergy in the care and treatment of the whole man.

Rev. Dr. Paul B. McCleve

Dr. McCleve is Director, Department of Medicine and Religion, American Medical Association, Chicago, Illinois.

SMITH, KLINE & FRENCH TO AWARD FOREIGN FELLOWSHIPS

The Association of American Medical Colleges announced today that Smith Kline & French Foreign Fellowships for Medical Students will be awarded again next year. The Fellowships provide approximately 30 students with the opportunity to assist and observe physicians for at least ten weeks, at rural medical stations in remote and underdeveloped areas of Latin America, Asia, Africa, and Oceania.

December 31 Deadline

Dr. Ward Darley, executive director of the Association, stated that the Association is now accepting application from junior and senior medical students for the Fellowships and that application forms and brochures have been sent to all medical school deans. The closing date for submitting applications is December 31, 1963.

The Fellows gain firsthand experience with diseases not common in the United States, and they are exposed

to unusual clinical and preventive health problems in societies and cultures different from their own. In Afghanistan, Peru, Borneo, Uganda, and other countries desperately in need of medical aid, students have made significant contributions to international medicine and to better understanding between peoples.

123 Students; 40 Foreign Countries

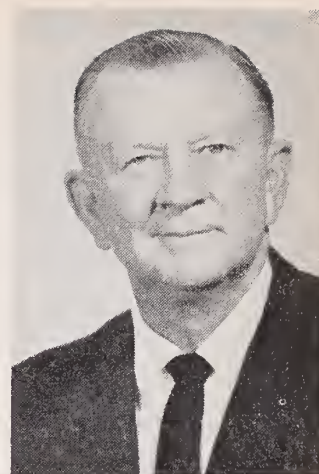
During the past four years, 123 students have worked in 40 foreign countries on grants totaling \$200,000 provided by the Philadelphia pharmaceutical firm of Smith Kline & French Laboratories. Fellowship grants cover travel and living expenses.

Students should contact their deans for instructions and application forms.

For additional information, write to SK&F Foreign Fellowships, AAMC headquarters, 2530 Ridge Avenue, Evanston, Illinois.

MEDICAL EDUCATION TODAY

GEORGE R. DILLINGER, M.D.



THE BIG PROBLEM in medical education today is that the pre-clinical and clinical chiefs are only infrequently present to teach the students on the ward. Residents, assistants and research fellows are teaching the undergraduate student of medicine. The students cannot develop a philosophy of medicine without contact with their seniors and the older members of the medical school faculty. In the present method of teaching, chiefs of service spend some time with their research assistants and residents and not enough time with the undergraduate students of medicine.

Misdirected Function

Federal government, the public and many misdirected scientists who advise congress, fail to understand the dependence of research on education and the dangers to both when the function of the medical schools is thrown askew. Consequently, some of them have the idea that a billion dollars spent in research will find a cure for cancer; as a result of this, some seven to eight per cent of medical school graduates now do not go into practice at all, do not even bother to take the state boards; they go into research.

Historically the same thing is happening now that happened to German Medical Education in the early 1900's when the best brains were siphoned off from the medical school and segregated into research institutions. Medical education then deteriorated to a low level. This is the socialists' road to educational oblivion.

No man should be dean of a medical school unless he is a clinical teacher, teaching on the ward, and no member of the faculty who is head of a department, except the strictly preclinical scientist, should be other than a practicing clinician.

What is Medical Education? The best definition: the Science and Art of medicine deals with the concept of disease and diseases, and the similarities and diversities of diseases, and all the relationship among

them, whether structural, physiological, biochemical, psychological or ecological. "In diagnosing different diseases we often use entirely different types of fundamental criteria, we may have a concept of disease based upon gross anatomical defects, microscopic anatomical changes, so-called specific deficiencies, genetic aberrations, physiological, or biochemical abnormalities, constellations of clinical symptoms and signs, organ and symptom involvement and even just description of abnormalities."

"In the final analysis, the universities and their medical schools cannot escape substantial responsibility for the kind of care a society receives. They select the medical students, guide their education, award their degrees, and advise them about postgraduate training."

"As physicians we participate in a social contract governing relationships with our clients or patients—the consumers."

What is a physician? A physician is one qualified by law to practice the healing art, including medicine and surgery. The unwritten social contract and the law delegates to our profession responsibility for helping society cope with individual and collective health problems.

Throughout society there is a revolution of rising expectations with respect to medical care. There is need to designate:

1. The extent to which we are to emphasize the importance of providing first rate, primary continuing personal, preventive, and curative medical care of high quality to individuals and families;
2. The kinds and numbers of physicians to provide this care; and
3. The best place or places to provide it.

The university and the medical school must accept the responsibility of the need to constantly redefine the problems of health and disease in communities—local, regional, national, and international, served by the medical school. A second responsibility is to define with considerable precision the broad

PRESIDENT'S LETTER / Continued

content of the physician's job. Not only the job in university teaching hospitals, but that of all practicing physicians; to family physicians, general practitioners, specialists and consultants in office and hospitals, and to physicians working in health departments and industrial clinics. The third responsibility of the medical school is to determine the extent of need for physicians to give primary, continuing personal, preventive and curative medical care; and the degree to which such care could be given to nurses, feldschers, medical corpsmen, medical aides, or some entirely new kinds of health personnel.

Relinquished Responsibilities

At the graduate level, the American universities and medical schools have almost completely relinquished their responsibilities for setting standards and regulating graduate education. That is one of today's big problems. The medical schools years ago delegated these powers to the specialty boards. There are no intrinsic reasons why the schools should not accept responsibility for this sector of education as they have for other sectors of university graduate work. No progress is likely to be made until the universities decide that:

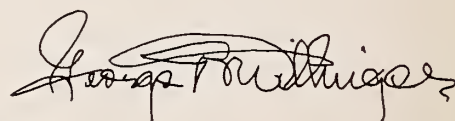
1. It is essential for the physician to give primary, personal medical care.

2. Universities are the institutions primarily responsible for setting both undergraduate and graduate educational objectives and standards; and

3. Adequate talent, space, budget for teaching, care of patients and research are essential.

The only degree granted by the medical school today is usually that of M.D. Some schools or universities do grant other degrees, but these are in a great minority.

Why, after granting the degree Doctor of Medicine, where a man spends adequate time in the university hospitals and clinical practice, should he not be granted a Masters Degree in such specialties as Surgery, Medicine, Public Health or Psychiatry? Then with further training and research a Ph.D. in the specialty of his training?



President, Medical Association of Georgia

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DEUS EX MACHINA

Robert F. Mabon, M.D., *Atlanta*

HARVEY CUSHING, in his critical summation of brain tumors in 1932, revealed an overall operative mortality rate of 13.9 per cent. This represented 2,023 tumors personally operated by him. In quoting Leonardo da Vinci, "It is a mediocre pupil who does not excel his master." Dr. Cushing continued by saying, "A surgical record far more creditable than that given herein would certainly be attained by most of them," meaning, of course, his understudies as well as future generations of neurosurgeons. It is doubtful that many neurosurgeons today manage to attain this figure and in some neurosurgical Valhalla, Harvey Cushing still occupies a highly secluded niche.

Justly Proud

Neurologic surgeons can be justly proud of the introduction of newer techniques to locate and identify intracranial neoplasms, namely: electroencephalography, cerebral arteriography, photostan and ultrasonic impulse devices as well as the very recent developments such as infra-red scans. Utilization of the edema reducing drugs, namely urea, and the use of hypothermia and other ancillary surgical props have proved of great help in the overall reduction of operative mortality, especially of the more complex vascular lesions. The adroit scientific methods employed by the contemporary anesthesiologists have vastly enhanced one's chances of survival in brain surgery. However, under the cold, objective scrutiny of an unprejudiced observer, there is a chilly, pervasive feeling that the surgical mortality, particularly of the intracranial gliomas, is

very little, if any, lower than the rate presented by Cushing in his 1932 monograph.

Forward Looking

We must look forward to a greater understanding of what makes normal tissue suddenly decide to show anaplastic tendencies; we must know more about the intra-cellular, especially the intra-molecular microbiochemical physiology before we can undertake to break par in this hazardous game of treating brain tumors. It is necessary to be constantly on the alert, in view of the recent rapidly successive breakthroughs in technological research in this space age, to take advantage of the many discoveries which could prove applicable to the operating suite. It is imperative to understand the newer concepts of genetics and the promising brilliant discoveries of the DNA and RNA inheritance formulas since herein may lie the answer to the enigma of the malignant intracranial tumors. It is not enough to be proud of the occasional patient cured of a meningioma but, rather, to be constantly humbled by the apparent impossible task of solving the riddle of the life history of intracranial tumors, particularly those arising from nervous tissue. The neurosurgeon cannot afford to be arrogant because, as was so aptly stated by Foster Kennedy, "He who cares for patients suffering from brain tumor must bring to his problem much thought and stout action. There is need also of a formidable optimism, for the dice of the gods are loaded."

1211 West Peachtree Street, N.E.

Approved by Professional Education Committee, Georgia Division ACS.



THE DIAGNOSIS OF TETRALOGY OF FALLOT

F. William Dowda, M.D., *Atlanta*

IN ORDER to diagnose Tetralogy of Fallot, one simply has to keep in mind the actual abnormalities which are usually found in this condition and the clinical manifestations of these abnormalities. In essence, the Tetralogy of Fallot consists of a large ventricular septal defect which usually approximates the size of the aortic valve and a pulmonary stenosis which commonly is infundibular in type. The actual amount of outflow from the pulmonary ventricle through the aortic orifice is dependent not on the size of the ventricular septal defect or the amount of overriding of the aorta but on the amount of the pulmonary stenosis. Because of the pulmonary stenosis, the right ventricle shunts the blood through the interventricular septal defect into the aorta, and because of the increased work-load of the right ventricle it becomes hypertrophied; however, this hypertrophy usually does not manifest itself on X-ray—the routine PA projection. This right ventricular hypertrophy is of significant magnitude to manifest itself on the EKG and produce an EKG of the adaptation variety.

Loud Murmur

The outflow of blood through the interventricular septal defect produces a systolic murmur usually rather loud in intensity. This is indistinguishable from the systolic murmur which one runs into with a routine interventricular septal defect; however, due to the pulmonary stenosis, the pulmonary second sound is usually absent. Absence of the pulmonary second sound is characteristic of this condition as the second sound is usually widely split in interventricular septal defects. In addition to this, congestive heart failure is extremely rare in Tetralogy of Fallot and in severe interventricular septal defect is relatively common. The infundibular pulmonary stenosis does produce a finding which sometimes is detectable on X-ray, a concavity in the region of the pulmonary trunk. A cavity in the region of the trunk may not be observed in those children in which the thymus gland is superimposed in this area and produces a shadow which looks like the pulmonary artery segment.

The clinical picture of Tetralogy of Fallot ordinarily

is not severe until the first or second year, however, in cases of severe pulmonary stenosis and/or pulmonary atresia, the symptoms may have much earlier onset and due to the admixture of venous blood, the cyanosis, polycythemia, and clubbing come on at a very early age. Conversely, however, patients in which the pulmonary stenosis is reasonably mild and the majority of the blood is shunted into the pulmonary artery instead of the aorta, may be acyanotic except under situations of rather marked exertion or a high altitude when pulmonary blood pressure is increased.

Helpful Point

In other congenital malformations in which valvular stenosis is involved, post-stenotic dilatation of the pulmonary artery is very common. This is a helpful differential point in cases such as pulmonary stenosis with combined right to left shunt at the atrial level.

Again let us retrace our steps in the diagnosis of this interesting and most common of the cyanotic congenital malformations. These patients present themselves with a harsh systolic murmur along the left parasternal border which may be accompanied by a thrill. It is usually not pan-systolic duration. In the pulmonic area, there may be a sustained systolic ejection murmur depending on the degree of pulmonary stenosis and this murmur usually diminishes in intensity with inhalation of Amyl Nitrite. The EKG shows an adaptation type of right ventricular hypertrophy. The chest film may show nothing or in some instances depending on the degree of infundibular stenosis, there may be a concavity in the region of the pulmonary artery segment. The second sound in the pulmonary area is not split. Typically these patients give a history of squatting and cyanosis; however, at times this cyanosis may be precipitated only by exertion, and before a definitive office diagnosis is reached, it is wise to exercise these patients to determine if cyanosis can be produced.

490 Peachtree Street, N.E.

Prepared at the Request of the Committee on Professional Education of the Georgia Heart Association.



VOLUNTARY AND OTHER ROUTINE ADMISSIONS TO MILLEDGEVILLE STATE HOSPITAL

James B. Craig, M.D., *Milledgeville*

THE MILLEDGEVILLE STATE HOSPITAL accepts all patients recommended for hospitalization by the courts of the state and those requesting admission on a voluntary basis when facilities are available.

The ever increasing demands by the public for services in the areas of mental health place a greater responsibility upon the physician to have at his disposal the knowledge necessary to guide and direct his patients for treatment when needed.

A great step forward was made in the field of mental illness in Georgia with the adoption of the Mental Health Act by the General Assembly. It is our opinion that many Georgians will benefit from this type of legislation.

New Commitment Law

In 1960 the General Assembly of Georgia passed a new commitment law whereby a patient could be admitted to the hospital without being adjudicated as insane. This is referred to as the "1960 Law" and is more acceptable to the public. This law does not refer to the patient as insane or a lunatic, but as being mentally ill or in need of psychiatric hospitalization. The patient does not lose his civil rights when admitted under this type of commitment and this tends to improve the patient's attitude toward his impending admission to the hospital.

In the Mental Health Act, mental illness is defined as "Mentally ill person shall mean a person who is afflicted with a psychiatric disorder which substantially impairs his mental health; and because of such psychiatric disorder requires care, treatment, training or detention in the interest of the welfare of such person or the welfare of others of the community in which such person resides." This act also provides for voluntary admission for an unspecified length of time.

The Health Department has adopted a program whereby a person who is in need of psychiatric hospitalization may voluntarily admit themselves to the

Milledgeville State Hospital. There have been many misconceptions as to what constitutes an acceptable voluntary admission. "Voluntary Admission" should within itself be self-explanatory. Included in this publication are admission policies and procedures plus general information concerning the hospital. The purpose of this article is to serve as a guide for members of the medical profession.

The following are some suggestions which should be followed in referring a patient to the Milledgeville State Hospital for consideration of voluntary admission. Voluntary admissions are usually arranged through your local Health Department; however, in the absence of a Health Department in your community, admission may be arranged through a local physician. A licensed physician should complete form MH 1.11, "Physician's Certificate for Voluntary Admission," recommending admission of patient for hospitalization. This form may be secured from the local Health Department.

Referral to Health Department

The patient should then be referred to the local Health Department where form MH 1.12, "Application for Voluntary Admission" will be processed along with the completion of a brief history blank. The patient should be accompanied to the hospital by a relative or friend. Arrangements must be made with the hospital in advance for confirmation of availability of beds. This may be done by telephone or in writing.

The patient should be screened thoroughly as to their receptiveness to admission to the Milledgeville State Hospital and must agree to submit to all the rules and regulations of the hospital. It is important that the patient have sufficient mental clarity to be responsible for and willingly sign the Application for Voluntary Admission. If a patient has to be coaxed, persuaded, or threatened to come to the hospital and does not fully recognize the nature of the hospital,

he would not make a suitable subject for voluntary admission. Oftentimes this type of patient will not remain in the hospital for any length of time. The patient will not have benefited and the professional personnel have lost a great deal of time in making the necessary examinations. With over 12,000 patients and limited personnel, time is very valuable in the state hospital. A voluntary patient may request a discharge from the hospital at anytime by addressing the Superintendent in writing and requesting to leave the hospital. We must then discharge the patient forthwith. However, if in the opinion of the Superintendent, the release of a voluntary patient would be unsafe for the patient or others, the request for immediate release would not be approved. This patient can be kept in the hospital in spite of his notice of his desire to leave for three days, exclusive of Saturdays, Sundays, or holidays. This provides time for arrangements to be made to have the patient returned to his county of residence for the initiation of involuntary admission procedures through the Court of Ordinary. If there is any doubt as to whether a patient will remain in the hospital until his treatment has been completed, he should be referred to the County Court of Ordinary.

Patients Referred

Patients who have a problem with alcohol or drugs should be referred to the County Court of Ordinary for involuntary admission.

A patient will not be accepted on a voluntary basis when criminal charges or indictments are pending against him. Sexual deviates should also be referred to the County Court of Ordinary.

A voluntary patient must agree for the doctors at Milledgeville State Hospital to administer any type of treatment deemed advisable.

Prepared at the request of the Sub-committee on Mental Health of the Medical Association of Georgia.

Patients under the age of 18 are not usually suitable candidates for the voluntary admission program. Rare exceptions are made and then a parent or guardian has to sign the voluntary admission paper for the patient. It is always necessary to make prior arrangements with the hospital for a minor to be accepted before sending them to the hospital. The hospital reserves the right to accept or reject a minor even on an involuntary basis.

Persons who have a severe or chronic mental illness and who require long-term treatment should be committed through the County Court of Ordinary, as it is felt this is a more appropriate procedure, in that, we can hold them until it is felt they are well enough to assume their place in the community.

Criteria

Acceptance of a patient on voluntary admission depends on the nature of the illness, the responsiveness of the patient, and the availability of the facilities of the hospital. Voluntary admissions should rarely be an emergency, and it is strongly recommended that such cases be referred to the County Court of Ordinary.

When a patient does not meet the qualifications for voluntary admission, the Ordinary should be encouraged to use the 1960 Law in committing the patient unless there is need for a guardian to be appointed.

Patients should be encouraged to report to the hospital no later than 4:30 p.m. and during a regular week day. Voluntary admissions are not usually accepted at the hospital on Sunday. This is beneficial to both the patient and the hospital as it expedites their admission.

Additional information may be obtained by contacting the Milledgeville State Hospital Admissions Department.

TWENTY-SEVENTH ANNUAL NEW ORLEANS GRADUATE MEDICAL ASSEMBLY TO CONVENE

The twenty-seventh annual meeting of The New Orleans Graduate Medical Assembly will be held March 2, 3, 4 and 5, 1964, with headquarters at The Roosevelt Hotel.

Nineteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. The program will include 55 informative discussions on many topics of current medical interest, in addition to clinico-pathologic conferences, symposia, medical motion

pictures, round-table luncheons and technical exhibits.

Following the meeting in New Orleans, arrangements have been made for a clinical tour to Europe leaving via air on March 7. The itinerary includes visits to Lisbon, Madrid, Rome, Vienna, Berlin, and Paris, returning on March 28.

Details of the New Orleans meeting and the tour are available at the office of the Assembly, 1430 Tulane Avenue, New Orleans, Louisiana 70112.

1963-64 CALENDER OF MEETINGS

State

- October 9, and continuing for 12 weeks—"Psychosomatic Medicine Conferences" sponsored by the Department of Continuing Education, The Medical College of Georgia, Augusta.
- January 14-16, 1964—"Thirteen Cardiacs" sponsored by the Department of Continuing Education, The Medical College of Georgia, Augusta.
- February 9, 1964—Seminar on "Georgia's Mental Health Program — What Can We Do Now?" sponsored by the Mental Health Committees of MAG and WAMAG, Milledgeville State Hospital, Milledgeville.
- February 10-14, 1964—"Hypertension and Its Complications" sponsored by the Department of Continuing Education, The Medical College of Georgia, Augusta.
- February 17-19, 1964—Atlanta Graduate Medical Assembly, Atlanta Biltmore Hotel, Atlanta.
- February 18-20, 1964—"Obstetric Problems in Private Practice" sponsored by the Department of Continuing Education, The Medical College of Georgia, Augusta.
- March 18-20, 1964—"Three Days of Advanced Electrocardiography and Vectorcardiography." Postgraduate course sponsored by the Department of Medicine, Emory University School of Medicine, Atlanta.
- March 19-21, 1964—Annual Meeting of the Georgia Society of Ophthalmology and Otolaryngology, Callaway Gardens, Pine Mountain, Ga.
- May 3-6, 1964—110th Annual Session of the Medical Association of Georgia, Macon, Ga.

Regional

- January 5-8, 1964—First Annual Postgraduate Seminar in Anesthesiology sponsored by the University of Miami and University of Florida Schools of Medicine, Miami Beach, Fla.
- January 13-17, 1964—Postgraduate course sponsored by the American College of Chest Physicians on Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, Miami Beach, Fla.
- January 27-29, 1964—American College of Surgeons, Lord Baltimore Hotel, Baltimore, Md.
- January 30-31, 1964—Symposium on "Scintiscanning in Clinical Medicine," sponsored by the Department of Radiology, Bowman Gray School of Medicine, Winston-Salem, N. C.

- February 12-16, 1964—American College of Cardiology, Roosevelt Hotel, New Orleans, La.
- February 29-March 5, 1964—International Academy of Proctology, Deauville Hotel, Miami Beach, Fla.
- February 29-March 6, 1964—American College of Allergists, Americana Hotel, Bal Harbour, Fla.
- March 1-6, 1964—American College of Allergists Graduate Instructional Course and 20th Annual Congress, The Americana, Bal Harbour, Miami Beach, Fla.
- March 2-5, 1964—New Orleans Graduate Medical Assembly, Roosevelt Hotel, New Orleans, La.
- March, 1964—Postgraduate Courses sponsored by the Department of Continuing Education of the University of Tennessee Medical Units: March 9-13—"Radiology;" March 19-21—"Surgery of the Hand;" March 25-27—"Obstetrics and Gynecology."
- March 16-19, 1964—American College of Surgeons (sectional meeting for surgeons and graduate nurses), Roosevelt and Jung Hotels, New Orleans, La.
- March 21-28, 1964—Southeastern Surgical Congress, held aboard the S.S. Hanseatic. Cruise will begin March 21, sailing from Ft. Lauderdale, Fla. and returning to the same port on March 28. Stops to include St. Thomas, San Jaun and Nassau.

National

- September 15, 1963-June 15, 1964—Nine month tutorial program in Cardiology offered by the Institute for CardioPulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.
- January 6-March 14, 1964—Ten week Postgraduate course in Tropical Health sponsored by the Stanford University School of Medicine, Stanford Medical Center, Calif.
- January 12-18, 1964—Tenth Annual General Practice Review, sponsored by the University of Colorado School of Medicine, Denver, Colo.
- March 16-28, 1964—Postgraduate Course in Laryngology and Bronchoesophagology sponsored by the Department of Otolaryngology, University of Illinois College of Medicine.

APPLICATIONS NOW OPEN IN SEVENTH PROGRAM OF WYETH PEDIATRIC RESIDENCY FELLOWSHIPS

Wyeth Laboratories has announced that applications are now being accepted for its seventh program of Pediatric Residency Fellowships.

Eligible to apply for the fellowships are interns and young physicians who, while having a strong desire to specialize in pediatrics, would find it difficult or impossible to finance the two-year postgraduate training required for Board certification.

Each Wyeth Pediatric Fellowship provides \$4,800 for the two-year period. Monthly allowances are made directly to recipients, in addition to the stipends normally paid residents by the institutions where they are in training. Fellows are free to choose their place of residency from among institutions accredited by the AMA's Residency Review Committee of the Council on Medical Education and Hospitals, the American

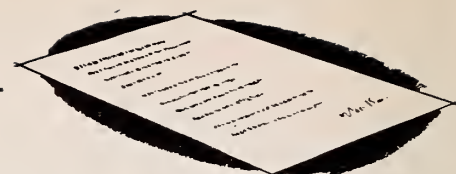
Board of Pediatrics, and the American Academy of Pediatrics.

Applicants must be citizens of the United States or Canada, and awards are limited to interns, young physicians who have recently completed internships, physicians coming out of the armed services or U. S. Public Health Service, or to research Fellows.

Wyeth takes no part in the selection of the Fellows. Instead, award recipients are chosen by a special volunteer Selection Committee of pediatricians who, collectively, represent outstanding accomplishments in the fields of pediatric practice, research and teaching.

Inquiries concerning the program should be directed to Dr. Philip S. Barba, University of Pennsylvania School of Medicine, Philadelphia 4, Pennsylvania.

ABSTRACTS BY GEORGIA AUTHORS



Llorens, Alfred S., M.D.; J. Howard Griner, M.D.; and John D. Thompson, M.D., 69 Butler Street, S.E., Atlanta 3, Georgia, "Maternity Mortality at Grady Memorial Hospital," *Am. J. Obst. & Gynec.* 87:386-393 (Oct. 1) 1963.

Maternal deaths at Grady Memorial Hospital, Atlanta, Georgia, were studied for a 13-year period beginning January 1, 1949, and ending December 31, 1961. During this period there were 80,403 live births and 97 maternal deaths. Of the total maternal deaths, 22 were of white patients and 75 were of Negro patients. The total maternal mortality rate for this period was 12.1/10,000 live births. Deaths attributed to direct obstetric causes numbered 66 (68%). Of these, hemorrhage accounted for 16 (16.5%), toxemia accounted for 16 (16.5%), and infection accounted for 23 (23.7%). Deaths from indirect obstetrical causes numbered 17 (17.5%). There were 12 deaths (12.4%) from non-related causes. The maternal mortality rate was found to increase as the age and parity of the patient increased. Death from septic abortion was the most frequent cause of maternal mortality. There was a high incidence of death from cerebrovascular accidents in toxemic patients. The findings of this study are discussed and the need to improve maternity services for the indigent obstetrical patient in the urban community of the South is stressed.

Coles, M. Robert, M.D., 5 Forsyth Street, Room 201, Atlanta 3, Georgia, "Southern Children Under Desegregation," *Am. J. Psychiat.* 120:332-344 (Oct.) 1963.

This paper describes a study by a child psychiatrist of Negro and white children in newly desegregated schools of the South. High school youths in Atlanta and first and second grade children in New Orleans were followed over two years of school time. They and their families were seen weekly in Atlanta, or monthly over a period of several days in New Orleans. Some of their teachers were also seen. Briefer interviews were held in cities of Arkansas, Tennessee, and North Carolina, contrasting long term studies with shorter evaluations. Taped interviews and drawings were collected and games were used.

Negro children, despite exposure to serious social tensions, have survived as pioneers in desegregation with remarkable absence of major psychiatric or medical symptoms. So long as they have no prior emotional illness, they call upon a variety of psychological maneuvers to deal with a world which they are reared to regard circumpectly. For them, attendance at a desegregated school offers stresses similar to those daily encountered, this time, however in some hope of ending them. However, their drawings and games or, slowly, their less resistant and guarded conversations, reveal their

long standing doubts about their own worth and possibilities as respected human beings. Various psychological maneuvers must be mobilized to protect themselves from such fears and anxieties, and these can be slowly documented.

White children will respond to desegregation in their own ways, depending upon their family background, their age, and their individual nature and wishes. Attitudes toward their new Negro classmates varied from compassion or indifference to strong aversion, though these responses are not necessarily fixed, but may change over a period of time. Families and children whose segregationist sentiments are passionate and relatively inflexible can be clinically differentiated from those for whom segregation is more a social habit, long held but slowly dispensable when opposed by other customs or wishes, such as law and order, or open schools.

Teachers and parents also must make major accommodations in a social crisis like this, with its collision of old traditions with daily concerns: teachers for the integrity of their work and parents for the continuing education of their children.

Maholick, Leonard T., M.D., The Bradley Center, Inc., Columbus, Georgia, "The Discharged Mental Patient," *G.P.* 28:116-120 (Oct.) 1963.

"The mentally ill can come back." Only a few years ago, this was the battle cry across the nation. Oddly enough, this excellent advertising slogan predicted what is occurring today—the return to the community of the discharged mentally ill patient in increasing numbers. Now the problem is to keep him at home—with his family, relatives, friends and co-workers.

The family physician can, if he will, play a singularly important role in rehabilitating the patient after he leaves the hospital.

In order for the physician to operate comfortably and at a relatively high level of efficiency, his care and treatment armamentarium should be expanded to include: (1) the development of a system for collecting maximum personal data about the patient in a minimum amount of time; (2) knowledge of the values and limitations of therapeutic talking time; (3) knowledge of the significance of interviewing and its scheduling; (4) knowledge about the uses and abuses of psychotropic drugs; (5) knowledge of other helpful community resources; and (6) the development of a consulting relationship with an acceptable psychiatrist.

Stephenson, Robert H., M.D., 710 Peachtree Street, N.E., Atlanta 8, Georgia, "Conservative Surgical Treatment of Complicated Duodenal Ulcer," *Am. J. Gastroenterol.* 40:232-238 (Sept.) 1963.

Though gastrectomy and hemigastrectomy have proved to be satisfactory operations for the treatment of complicated duodenal ulcer, the accumulating hoard of patients with undesirable results is disturbing.

Prompted by recent contributions to the knowledge of gastric physiology, some thoughtful surgeons are reinvestigating the more conservative antrum-preserving operations for the treatment of complicated duodenal ulcer. The philosophy of the "upgraded" or "staged" approach to the problem is considered and the rationale for the employment of gastroduodenostomy as a first stage procedure is presented. A program for adequate investigation of this approach is outlined.

Smith, Robert S., M.D., Emory University, P.O. Box 459, Atlanta 22, Georgia; Alfred S. Ketcham, M.D., and Louis B. Thomas, M.D., Bethesda, Maryland, "Carcinoma of the Uterine Cervix," *Cancer* 16:1105-1112 (Sept.) 1963.

This report presents an analysis of the clinical course of 222 patients admitted with the diagnosis of carcinoma uterine cervix, for study of the effect of primary excisional therapy. Almost one half were radiation failure cases, and 20 per cent were found inoperable after admission to the hospital. An additional 14 per cent were explored and found to have non-resectable disease because of extension of tumor beyond the pelvis. Definitive excisional surgery was performed on the remaining 135 with an operative mortality of 5.8 per cent. A 37 per cent cumulative survival at 60 months was observed. Survival varied with the stage of the disease from 100 per cent to 71 per cent for the few Stage A, B or C cases to 14 per cent for those with Stage F disease. Those subjected to radical hysterectomy or anterior exenteration had a 57 per cent survival at 60 months while the total exenteration group experienced a 16 per cent survival. This total salvage of almost one-third is especially significant because it occurred in a group of patients with advanced disease, one-half of whom had been treated unsuccessfully by other means of therapy.

Smith, Robert S., M.D., Emory University, P.O. Box 459, Atlanta 22, Georgia; Alfred S. Ketcham, M.D., Richard A. Malmgren, M.D., and Elizabeth W. Chu, M.D., Bethesda, Maryland, "Cancer Cell Wound Contamination Associated with Surgical Therapy of Carcinoma of the Cervix," *Cancer* 16:1100-1104 (Sept.) 1963.

Twenty-three per cent of 98 cervix cancers treated by radical surgery had cytologic evidence of cancer cell contaminated wounds. Positive wound washings were more frequently obtained from patients with late stage of disease, those with lymph node metastases or when tumor extended to the line of surgical resection. Follow-up studies of patients with positive

wound washings suggest that they have an increase in local recurrence and a decreased survival. Local wound treatment with 0.5 per cent formaldehyde, or formaldehyde plus the use of picric acid sutures was associated with a decreased incidence of local recurrent cancer. When positive wound washings were obtained the local recurrence rate was high and was not influenced by local chemotherapy. The same high incidence of local recurrence was observed when washings were negative for cancer cells and no wound therapy was given. However, when wound washings were negative and local chemotherapy was used, the incidence of local recurrence was about one fourth that seen in the other groups.

Schlant, Robert C., M.D.; John T. Galambos, M.D.; Wade H. Shuford, M.D.; William J. Rawls, M.D.; Thorne S. Winter III, M.D.; and F. K. Edwards, M.D., 69 Butler Street, S.E., Atlanta 3, Georgia, "The Clinical Usefulness of Wedge Hepatic Venography," *Am. J. Med.* 35:343-349 (Sept.) 1963.

A method is described in which contrast material is injected through a catheter wedged in an hepatic vein. The method frequently gives qualitative information of value in distinguishing between a normal and an abnormal fine hepatic vascular pattern, in the demonstration of collateral vessels and the patency of the portal vein in patients with cirrhosis and portal hypertension and perhaps in the demonstration of a vascular pattern which may be characteristic of hepatoma.

McCain, John R., M.D., and James F. Olley, M.D., 384 Peachtree Street, N.E., Atlanta 8, Georgia, "The Effect of an Oral Decongestant Upon the Menstrual Cycle," *Am. J. Obst. & Gynec.* 87:354-363 (Oct. 1) 1963.

A correlation has been described between certain areas of the nasal mucosa, the "genital spots," and the cyclic changes of the endometrium. The investigation was made upon 157 women, all of them private patients. The oral nasal decongestant employed was in the form of a sustained release capsule, Ornade.* The conditions which showed the most favorable response were functional menorrhagia and endometriosis. Decreased bleeding was reported by 74.6 per cent of the women treated for functional menorrhagia. The pain decreased or disappeared, in 86.7 per cent of the patients who were treated for endometriosis. Patients with dysmenorrhea from conditions other than endometriosis improved in 61.5 per cent of the cases. Patients with metrorrhagia showed little evidence of improvement; the menstrual irregularity was improved in only 21.4 per cent of the 28 women with this abnormality.

The mechanism by which the oral nasal decongestant produces its apparent effect is not known. If the histologic interpretation of the endometrial changes is correct, it would not seem to administer systemically an oral nasal decongestant, especially

those that are long acting, to pregnant patients. Changes in the endometrium, particularly in the early weeks of gestation, could be detrimental to the developing embryo.

Gay, Brit B., Jr., M.D.; Robert H. Franch, M.D.; Wade H. Shuford, M.D.; and James V. Rogers, Jr., M.D., Emory Hospital, Atlanta 22, Ga. "The Roentgenologic Features of Single and Multiple Coarctations of the Pulmonary Artery and Branches," *Am. J. Roentgenol.* 90:599-613 (Sept.) 1963.

Pulmonary artery coarctation is characterized by single or multiple stenotic lesions of the pulmonary arterial branches. The stenoses may be short or long, peripheral or central, unilateral or bilateral. Pulmonary coarctation may be hemodynamically benign or associated with severe right ventricular and pulmonary artery systolic hypertension. Pulmonary coarctation is probably congenital in origin and is found as an isolated lesion in 40 per cent of reported cases. In the remaining 60 per cent, the most frequently associated anomaly is pulmonary valvular stenosis. Selective angiocardiology is essential in the diagnosis of this condition, which is much more frequent than formerly recognized. Roentgenologic features of pulmonary artery coarctations are presented in detail in a series of 15 patients. An anatomic classification into four basic types is proposed.

Asada, Makoto, M.D.; John T. Galambos, M.D.; Robert C. Schlant, M.D.; and William J. Rawls, M.D., 69 Butler St., S.E., Atlanta 3, Ga. "Effect of a Small, Circumscribed Hepatic Necrosis on Serum and Hepatic Enzyme Activities," *Am. J. Digest. Dis.* 8:639-648 (Aug.) 1963.

A small focal necrosis of the liver was produced without affecting the general condition of dogs by injecting 20 ml. 69 per cent sodium and methyl-glucamine diatrizoates into a catheter wedged in an hepatic vein. This was associated with a decreased serum glutamic oxalacetic transaminase enzyme activity of the injured tissue as compared with normal liver and correspondingly increased levels of (GOT), glutamic pyruvic transaminase (GPT), lactic dehydrogenase (LDH), and sorbitol dehydrogenase (SDH) activities in both hepatic venous and peripheral arterial blood. By 72 hours after injury, when regeneration was seen histologically, the enzyme activities, markedly depressed in the injured areas, were returning to normal. The increase of serum enzyme activity appears to be quite rapid during the first few minutes after hepatic injury and there is a slow secondary rise during the first hour thereafter. By 24 hours the serum enzyme activities returned to near normal. The enzyme activities in the peripheral arterial blood were not significantly different from those in the hepatic venous blood.

Transient elevations of serum enzyme activities were also noticed in human subjects who underwent diagnostic wedge hepatic venography.

Dallas, W. M., Jr., 2507 Willams Lane, Decatur, Ga. "Rupture-Separation of the

Cervical Trachea as a Result of Blunt Trauma," *Am. Surgeon* 29:529-531 (Aug.) 1963.

Two recent examples of transection of the cervical trachea incurred in automobile accidents are reported. Diagnosis is suspected in the presence of subcutaneous emphysema, appropriate injury, and respiratory distress. Palpable absence of the cervical trachea confirms the diagnosis.

Management by primary end-to-end anastomosis and venting tracheostomy is described. Results are uniformly good barring associated laryngeal fracture or recurrent nerve injury.

The high incidence of stricture following delayed repair is emphasized.

Martin, J. D., M.D.; Boyce S. Brice, M.D.; Frank C. Jones, M.D., and Carl A. Smith, M.D., Emory Hospital, Atlanta 22, Ga. "The Increasing Incidence of Perforated Appendicitis," *South. M. J.* 56:953-958 (Sept.) 1963.

Despite the enlightened state of our knowledge and keen diagnostic efforts, perforation of the appendix continues at a high rate. In this era of radical surgical triumphs and with advanced approaches in treatment, one would think that the incidence of perforated appendix would be markedly lower. Education of the public as to the seriousness of the disease must be as vigorous as it has been in heart disease and cancer.

The diagnosis of appendicitis is sometimes not easy; however, any individual with abdominal pain associated with nausea and vomiting for longer than twelve hours should be considered to have acute appendicitis until appropriate means prove otherwise. Frequently this may be determined only by conservative exploratory laparotomy.

Gastroenteritis is the condition most often confused with appendicitis and there are probably more abdominal tragedies in patients who meet this diagnosis than in any other.

The most common reasons for delay in operation for appendicitis are as follows:

1. Lack of appreciation for the seriousness of the problem.
2. Failure to show a high index of suspicion.
3. Inability to concentrate on the more common difficulties and ignore the obvious.
4. The inclination of physicians in this day of attention to special diseases to limit their sphere of interest.
5. Encouragement by the overcrowded daily schedule of the busy physician to use short cuts in arriving at diseases and administering the required treatment.

6. The margin of safety has been extended through reliance on antibacterial agents. The false sense of security is then short lived even though the course in less virulent forms may be aborted or made less severe.

In this review of 291 cases of appendicitis it is noted that 28.5 per cent were ruptured when operated upon. It is suggested that a plea for better public and professional appreciation of this common disease be made.

*Smith Kline & French Laboratories, Philadelphia, Penn.

THE ASSOCIATION



DEATHS

LON WOODFIN GROVE, 73, retired Associate Professor of Clinical Surgery at Emory University and Chief of Surgical Service at Henrietta Egleston Hospital for Children, died in Emory University Hospital October 9, 1963.

Dr. Grove also was retired as the medical director of Southern Bell Telephone and Telegraph Co. He retired in 1955 after 25 years' service, and was a member of the Pioneers Club of Atlanta.

Since his retirement he had been a member of the Honorary Staff, Egleston Hospital for Children, and a Clinical Associate Professor Emeritus of Surgery, Emory University.

Dr. Grove was a fellow of the American College of Surgeons, a fellow of the Southern Surgical Association, and a diplomat and founding member of the American Board of Surgery.

He was an honorary member of the Southern Medical Association, a member of the Southern Society of Clinical Surgeons, and a member of the Fulton County Medical Society, and the Medical Association of Georgia.

Born in Panola, Alabama, he was a 1912 graduate of the University of Alabama Medical School, and did post-graduate studies at the University of Pennsylvania and Harvard Medical School. Before coming to Atlanta in 1919, he interned at the Brice Insane Hospital in Tuscaloosa, Alabama, where he organized the Department of Surgery.

Dr. Grove was an honorary fellow of the Alpha Omega Honorary Medical Fraternity at the University of Alabama, was a member of the Editors and Authors Association of America, and was listed in Who's Who in America and Who's Who in the Southeast, and in the Directory of Medical Specialists.

He was a member of the Piedmont Driving Club, a life member of Capital City Club, a member of the Fifty Club, the Atlanta Art Association, the Atlanta Symphony Guild, and Atlanta Symphony Appreciation Society.

Dr. Grove entered the Army in 1917, and was stationed at the Walter Reed Hospital in Washington. He also served at the Red Cross Hospital No. 1 in Neuilly, France, served as Chief of surgical service at the U.S. Base Hospital No. 202 in Orleans, France, with the rank of major. In 1918, Dr. Grove was decorated by the French government for distinguished service to France. After his return to the United States, he was Chief of surgical service at the Staten Island Hospital, N.Y., and on the teaching staff of Columbia University of Physicians and Surgeons in New York City.

He was awarded a Distinguished Service Citation in 1959 by the Board of Trustees of Henrietta Egleston Hospital for Children for a quarter of a century as Chief of Surgery.

Surviving him are his widow, the former Dorothy Haverty of Atlanta, whom he married in 1923; daughters,

Mrs. Claiborne Glover, Jr., of Atlanta and Mrs. Henry Harris of Rome; a sister, Mrs. Frank Anderson of Union Springs, Alabama; a brother, Frank L. Grove of Montgomery, Alabama; five grandchildren and nieces and nephews.

JOHN CALVIN ROLLINS, born November 24, 1875, in Murray County, Georgia, practiced medicine in Dalton for 47 years. He moved after his retirement to College Park, where he died October 22, 1963, at his home.

An organizer of the Whitfield County Medical Society, Dr. Rollins was a member of the Georgia and American Medical Associations and the American College of Surgeons. He was also a member of the College Park Methodist Church and was a Mason and a Shriner.

He was a 1904 graduate of the University of Georgia Medical College in Augusta.

Dr. Rollins is survived by a daughter, Mrs. George F. Longina, Jr., and a son, John D. Rollins, both of College Park; a sister, Mrs. Jessie Yate of Ringgold; brothers, Arthur and Frank Rollins, both of Dalton; a daughter-in-law, Mrs. E. L. Rollins of Tifton, and three grandchildren and four great grandchildren.

SOCIETIES

The BLUE RIDGE MEDICAL SOCIETY held its Third Quarter meeting in Ellijay at the home of Marcus Berry and Mrs. Berry. In addition to full attendance by the members of the society, visiting guests included Jay Johnson of Gainesville and W. Lynn Hicks of Macon.

Dr. Paul B. McCleave, Director of the American Medical Association's Department of Medicine and Religion, spoke at the annual FIFTH DISTRICT MEDICAL SOCIETY meeting held November 7, at the Academy of Medicine, Atlanta. Dr. McCleave's subject was titled "The Care of the Whole Man." Clergymen representing several denominations were invited to attend the meeting and dinner preceding the meeting with Fulton, DeKalb and Rockdale physicians. Harrison Reeves, M.D., Chairman of the Medical Association of Georgia's Committee on Medicine and Religion, also participated in the program.

Corbett Thigpen, M.D., Associate Clinical Professor of Psychiatry at the Medical College of Georgia, Augusta, was the guest speaker at the annual Ladies Night of the MUSCOGEE COUNTY MEDICAL SOCIETY held October 16, at the country club in Columbus.

John Meier, M.D. of Albany presented the scientific program to the RANDOLPH-TERRELL-STEWART MEDICAL SOCIETY meeting held October 8, 1963, in Richland. Dr. Meier's subject concerned internal derangement of the knee.

The fall meeting of the SOUTHWEST GEORGIA MEDICAL SOCIETY was held in early October at Blakely. H. L. Lassiter, M.D. of Arlington presided. W. D. Lowery, Albany neurosurgeon, presented slides and films for the program.

Physicians from throughout the area attended a meeting of the THIRD DISTRICT MEDICAL SOCIETY October 17 at the Americus Country Club. Principal speakers at the meeting included Robert H. Vaughn, M.D., Columbus, who presented his paper on "Problems Concerning Esophageal Hiatus Hernias;" Louis A. Hazouri, M.D., Columbus, "Compression Nerve Root Syndromes: Cervical, Dorsal and Lumbar;" and Simone Brocato, M.D., Columbus, "Aortic Valve Lesions." Dr. Brocato was installed as President for the coming year and J. T. Christmas, M.D., Vienna, was named President-Elect and also named a Vice Councilor.

WASHINGTON COUNTY MEDICAL SOCIETY recently held their third session of the Stroke Clinic, October 11 in Sandersville.

THE WHITFIELD COUNTY MEDICAL SOCIETY in cooperation with the Medical College of Georgia sponsored a medical symposium held at Hamilton Memorial Hospital October 17 and 18 at Dalton. The program was supported by a grant from Merck, Sharp and Dohme.

Visiting speakers from the Medical College of Georgia were Dr. Wayne Greenberg, Assistant Professor of Medicine; Dr. George W. Smith, Professor of Surgery, Chief of Neurosurgery; Dr. James R. Teabeaut, Associate Professor, Department of Pathology; and Dr. Arthur C. White, Associate Professor Medicine.

Topics covered included papers on "Management on Non-Toxic Goiter," "Newer Antibiotics," "Head Injuries and How to Evaluate," "Forensic Medicine," "Feasibility of Spinal Tap," "Opportunistic Infections," and "Management of Hyperthyroidism."

A social hour and dinner rounded out the activities of the two-day session.

PERSONALS

Approximately 1,050 surgeons were recently inducted as new Fellows of the American College of Surgeons in cap-and-gown ceremonies during the annual five-day Clinical Congress of the world's largest organization of surgeons.

Those receiving this distinction from the State of Georgia at the 1963 Convocation are as follows:

Atlanta

Christian R. Moorhead
Ted L. Staton
Edward J. Waits
Frank L. Wilson, Jr.

Augusta

Roshdy Habib
Mason H. Shepherd
Jui-Ting Thomas Yeh

Brunswick

Joseph L. Owens, Jr.

Columbus

Lionel M. Yoe

Fort Benning

George J. Schonholtz

Griffin

Grady F. Duke

Lyons

John D. McArthur

Macon

Gordon W. Jackson

Milledgeville

Harry B. Johnston, Jr.

First District

G. J. PASTORIUS, Savannah, served as Alternate Delegate in the House of Delegates of the American Society of Anesthesiologists at its annual business and scientific meeting, November 2-6 in Chicago.

Second District

No News Submitted.

Third District

No News Submitted.

Fourth District

The doctors of Butts County were hosts October 22 at a dinner for the blood donors who have contributed a gallon or more to the blood program of Butts County.

Another \$60,000 shipment of drugs left Newnan, Georgia, in October for Korea. The drugs are donated by leading pharmaceutical companies periodically to BEN JENKINS, who spearheaded the movement to obtain medical aid for the needy Koreans.

Fifth District

A. H. LETTON, Atlanta, has been elected a delegate director of the newly constituted Board of Directors of the American Cancer Society.

The Thirty-first annual scientific meeting of the Georgia Pediatric Society was held October 24 at the Mayfair Club in Atlanta.

JOHN E. STEINHAUS, Atlanta, served as Delegate in the House of Delegates of the American Society of Anesthesiologists at its annual business and scientific meeting, November 2-6 in Chicago.

CHENEY C. SIGMAN, JR., of Atlanta recently attended the Southeastern Allergy Association annual meeting held October 10-11 in Asheville, N.C., and delivered a paper entitled, "Male Sensitivity and Respiratory Allergy."

J. WILLIS HURST, Atlanta, conducted ward rounds and conferences on Medical Education Day at Georgia Baptist Hospital September 17.

B. R. GENDEL spoke on "Recent Advances in Medical Genetics" at the Piedmont Postgraduate Clinical Assembly at Clemson, S.C., September 19.

SAM A. WILKINS, JR. of Atlanta spoke on "The Re-evaluation of the Rectal Bladder" at the Georgia Surgical Society meeting September 25-28 at Sea Island, Georgia.

THE ASSOCIATION / Continued

Mrs. F. Kells Boland, wife of F. KELLS BOLAND, Atlanta, was re-elected Vice President of the Georgia Society for Crippled Children and Adults on October 18 when the Society held its 13th annual meeting at the new Atlanta Easter Seal Rehabilitation Center, 1362 West Peachtree, N.W. WALTER L. BLOOM, Director of Medical Education and Research, Piedmont Hospital, Atlanta, and board member of the Georgia Society, was reappointed to the executive committee of the Easter Seal state organization. JOSEPH H. DIMON, III, Atlanta orthopedist, Medical Director of the Atlanta Easter Seal Rehabilitation Center, participated in the October 18th meeting by giving a presentation which traced the development of medicine into the present day rehabilitation team approach of specialists.

Sixth District

Three Macon physicians are listed in the eighth edition of the Marquis Who's Who publication of Who's Who in the South and Southwest United States. The biographical reference book lists BEVERLY WOOD FORESTER, who serves as Chairman of the Citizens Committee for Health and Progress and received the distinguished service award of the U.S. Junior Chamber of Commerce. He is Sixth District representative on the State Board of Health. MILFORD B. HATCHER, Past President of the Medical Association of Georgia, has served as a member of the State Hospital Study Commission, the state advisory commission, and the state Vocational Rehabilitation Agency. CLAUDE LEE PENNINGTON, a former resident in otolaryngology at Columbia Presbyterian Medical Center, New York, has published several papers on the ear and is Chairman of the Board of Directors of the Central Georgia Foundation for Speech and Hearing.

Seventh District

Rome physician, WILLIAM HARBIN, has recently announced plans for the establishment of a foundation to be known as the William Harbin Foundation, an organization which will supply small grants to aid individuals, organizations and schools in improving education and educational opportunities.

M. K. CURETON of Lafayette spoke to the Kiwanis Club of Rossville on October 21; his topic concerned medical care for the aged and was based on material in the film, "Operation Hometown."

MAG COUNCIL MEETING MINUTES

THE QUARTERLY MEETING of the Council of the Medical Association of Georgia was called to order at 2:15 p.m., September 28, 1963, Cloister Hotel, Sea Island, Georgia, by the Chairman Addison W. Simpson, Jr.

Dr. Dillinger was called on to give the invocation.

The members of Council in attendance were: Addison W. Simpson, Jr., Washington; George R. Dillinger, Thomasville; J. G. McDaniel, Atlanta; Walker L. Curtis, College Park; John Kirk Train, Savannah; John T. Mauldin, Atlanta; John S. Atwater, Atlanta; J. Frank Walker, Atlanta; Joseph B. Mercer, Brunswick; Charles E. Bohler, Brooklet; W. Frank McKemie, Albany; Frank A. Wilson, Leslie; Virgil B. Williams, Griffin; Floyd Sanders, Decatur; William Rawlings, Sandersville; Ralph N. Johnson, Rome; F. F. Eldridge, Valdosta; C. R. Andrews, Canton; Walter Brown, Savannah; H. D. Pinson, Augusta; Luther H. Wolff, Columbus; George H. Alexander, Forsyth;

Eighth District

Brunswick physician, JOE MERCER, spoke on October 24 to the Glynn County Junior High PTA, the PTA Council and Youth Organization officers.

SAM VICTOR was elected in early October as President of the medical staff of Memorial Hospital at Waycross. NEAL YEOMANS will serve as Vice President and R. C. SMITH as Secretary.

Y. F. CARTER, JR. of Nashville, Georgia, attended the 15th Annual GP Session held October 10-12 in Atlanta.

CECIL DAVID CASON of Blackshear is now associated in the general practice of medicine with H. K. HEATH, JR. and TIM RAY HEATH at offices located at 701 Elizabeth Street, Waycross.

Ninth District

PAUL T. SCOGGINS, Commerce, was elected President of Commerce Golf and Country Club, Inc., at the annual meeting of the organization held October 24.

At the invitation of the President of the National Association of Clinic Managers, W. B. SCHAEFER of the Medical Arts Clinic, Toccoa, appeared before the group October 9.

The Towns County Hospital at Hiawassee has recently installed Two-way radio equipment with a base unit at the hospital and Hooper's Drug Store. JOHN ACREE and LANIER NICHOLSON are two of the doctors who will have mobile units in their automobiles. The units enable the hospital to reach the doctors on a moment's notice in case of emergency.

WILLIAM H. GOOD, Toccoa, attended the annual convention of the American Association of Medical Clinics in Chicago, September 26-28. Dr. Good is associated with the Toccoa Clinic.

Tenth District

Doctors from Maine to Florida and Augusta to Seattle gathered in Augusta the weekend of October 5-6 for the 25th anniversary of their graduation from the Medical College of Georgia. HARRY B. O'REAR, President of the Medical College, was official host to the reunion. Attending the dinners were many of the professors who taught the group 25 years ago and are still active in the medical field.

Charles S. Jones, Atlanta; J. C. Brim, Pelham; C. T. Cowart, LaGrange; J. W. Yeomans, Jesup; P. T. Scoggins, Commerce; Linton H. Bishop, Atlanta; J. W. Chambers, LaGrange; Eustace A. Allen, Atlanta; Henry H. Tift, Macon; and P. D. Ellington, Augusta. Also in attendance were: Charles R. Smith, Columbus; Benjamin C. Wills, Savannah; and W. W. Moore, Atlanta. Mr. Richard Nelson, Field Representative of the AMA and Mr. John Moore, MAG Attorney, attended, as well as Mr. Milton D. Krueger and Mrs. Catherine Wooten, of the MAG staff.

Reading of Minutes

Mr. Krueger reviewed the minutes of the June, July, and August Executive Committee meetings, and June Council meeting. On motion duly made and seconded it was voted to approve the minutes as reviewed.

Mr. Richard Everett, Manager of the Cloister, was introduced and he welcomed the members of Council and explained the program of social events scheduled for the evening.

Treasurer's Report

Dr. Atwater gave the Treasurer's report. Dr. Chambers questioned the Southeastern States Hospitality Room expense for the AMA meeting as MAG is obligated for an amount not to exceed \$200.00. He was informed that this would be discussed at the time of the AMA Delegates' report. On motion (Curtis-Alexander) it was voted to approve the Treasurer's report as presented.

Legal Retainer Fee

Dr. McDaniel stated that at a meeting with the MAG Attorney an adjusted retainer fee to begin January, 1964, had been agreed upon. This meeting was held at the instruction of Council. On motion (McDaniel-Walker) it was voted to increase the retainer for the MAG legal counsel as recommended.

MAG Pension Plan

Mr. John Moore, MAG Attorney, stated that the pension plan will be submitted to the Internal Revenue Service as the next step for approval. There should be an election of three members of an Administrative Committee, called for in the pension plan, by Council, and Chairman Simpson was asked to make these appointments for announcement at tomorrow's meeting, and the signing of a Resolution, after adoption, by the three persons so designated by Dr. Simpson.

Physical Ownership of Repackaging Drug Houses

Dr. Dilinger read the AMA House of Delegates action on physician ownership of repackaging drug houses which made it unethical for a physician to own or hold stock in a repackaging drug house. On motion (Mauldin-Curtis) it was voted that a committee should be appointed by the Chairman of Council to investigate the repackaging drug houses in Georgia and report to Council the results of this investigation. On further motion (Walker-Mauldin) it was voted to mail a letter to the County Society Officers emphasizing this information.

Mental Health Committee Report

Mr. Krueger stated that Dr. James N. Brawner, Chairman of the Mental Health Committee, could not be present and had asked him to give this report. The Executive Committee had heard the reports prior to the Council meeting and had made the following recommendations to Council regarding certain items in the report as follows:

(1) The six items listed in the report made by Dr. Yochem following his attendance at the AMA National Congress of Mental Illness and Health, held in Chicago, October 4-6, 1962, are being implemented now or are in the process of being implemented.

(2) The actions and recommendations of the Mental Health Subcommittee had been reviewed by the Executive Committee and these actions taken:

(a) A rotating schedule of committee member appointments was approved but the recommendation that the Georgia Psychiatric Association Past President be appointed chairman each year was disapproved. Council approved the Executive Committee action on these two items.

(b) Invitation to Drs. Venable and Duval to Council meetings: It was recommended by the Executive Committee that Doctors Venable and Duval be invited to attend any meeting they desired but no special invitations could be tendered. Council voted to approve this action.

(c) Mental Illness Insurance Study Committee: The Executive Committee had voted to recommend to Council that it endorse the idea of insurance companies developing mental health illness policies and to publish this information in the *JMAG*. Council voted to approve this action.

(d) Formation of "Insurance Utilization Committee": The Executive Committee determined that the Health Insurance Council Liaison Committee, with Dr. W. W. Moore as Chairman, was studying this idea. Council then accepted this for information to await Dr. Moore's report on the meeting of his committee.

Talmadge Hospital Liaison Committee Report

In Dr. C. H. Richardson's absence Mr. Krueger gave background information about the function of this committee and reported on the meeting held September 15, 1963, in Augusta. Only one item of the report of the committee was questioned and that was regarding the matter of its being unethical to give

the name of the referring physician of patients admitted to the Talmadge Hospital. The committee had concurred in Dr. Rufus Payne's recommendation that the name be withheld. Council discussed this, and on motion (Wolff-Mercer) it was voted to refer this item back to the Talmadge Memorial Hospital Liaison Committee for further clarification. On further motion it was voted to accept Dr. Richardson's report, approve it with the exception of the item mentioned above, and to write a letter to him commending him and the committee members for the activity of this committee.

Relationship of Private Practice of Psychiatry to Proposed Governmental Programs

Dr. Charles R. Smith, President of the Georgia Psychiatric Association, was asked to present his item of business before Council. He discussed the intensive treatment program. This program was formerly operated through contract between the State Department of Health and the hospital. The State Department of Health, however, has recently stated that the "fee for service" basis would be terminated and any physician performing services would be considered a part-time employee of the State Department of Health. The Georgia Psychiatric Association is opposed to this and a consultation with Drs. Venable and Duval was to no avail in changing their ideas on this matter. The psychiatrists are now operating under this system under protest.

Dr. Smith then discussed the proposed plan through the "Kennedy program" of the establishment of Community Health Centers. The psychiatrists are opposed to this but if the Centers are established they should be under the supervision of the medical profession.

He then mentioned that the definition of "medical indigency" should be considered, as these people would be eligible if the above mentioned plan were established.

There was further discussion about state mental institutions and the fact that the Georgia Mental Health Institute (Briarcliff) would be operated by Emory on a closed staff and not open for Atlanta psychiatrists. He also mentioned voluntary admissions to Milledgeville.

After lengthy discussion Council asked Dr. Smith for recommendations or guidelines. He stated that he wanted Council to know that it was not desirable for physicians to work as part-time employees instead of on a fee for service basis, and he asked for endorsement by the Association in upholding the viewpoint that the State Health Department should not insist on physicians participating in this program on a part-time employee basis. At this point, Dr. Wolff suggested that Council recommend to the State Department of Health that it consider Community Health Center locations where psychiatrists are available and that treatment of all psychiatric patients be carried out on a fee for service basis. On motion (Wolff-Wilson) it was voted to ask Dr. Smith to prepare specific recommendations of the invasion of the private practice of psychiatry by the State Department of Health for submission to Council the next day, September 29, 1963, for action.

Constitution and Bylaws Board Report

Dr. Alexander gave the report for Dr. Elliott, who could not be present. The report is as follows: (1) Additional Delegates to MAG House of Delegates; (2) Voting Privilege of Vice Councilor Bylaws Change; and (3) Councilor Distribution Bylaws Change. There was discussion pro and con on more than one Councilor from any one county society. The report was received for information and will be brought to the December Council meeting in final form.

Medical Defense Committee Report

The Medical Defense Committee report was made by Dr. Charles S. Jones, Chairman, and was received for information.

Dr. Mauldin brought a report to Council suggesting that Council consider running its own insurance program. It is his opinion that it is very feasible and would save the members money.

On motion duly made and seconded it was voted that action be delayed on Dr. Mauldin's proposal until St. Paul has made their annual report, but that Dr. Mauldin's recommendations still be considered. It was suggested that this matter be publicized so that members whose premiums have been increased will be informed.

Relative Value Study Survey Report

Dr. Pinson made a progress report and stated that a complete

THE ASSOCIATION / Continued

report would probably be made at the December Council meeting.

Chairman Simpson, at this point, recessed the meeting at 5:20 p.m.

* * * * *

The Council meeting was reconvened at 8:25 a.m. by Chairman Simpson, and the business proceeded.

Relationship of Private Practice of Psychiatry to Proposed Governmental Programs

Dr. Benjamin C. Wills, Savannah psychiatrist, was asked to make his presentation in conjunction with Dr. Smith's of the previous day. He read excerpts from the Memorial Hospital of Chatham County Medical Staff Bylaws, Rules and Regulations which gave the Board of Trustees the right to amend the Bylaws, Rules and Regulations without the approval of the Medical Staff. He suggested the Bylaws be changed to allow more medical control. He also gave Council information regarding the encroachment of state control in the private practice of psychiatry by quoting from documents in his possession.

In line with the recommendation of more medical control Dr. Wills submitted the following Resolution:

Resolution

"Resolved that the governing body of any hospital, board of trustees, commission or other means of government shall not have the right to finally determine a medical issue or any issue by overriding the medical opinion or judgment."

After hearing this Resolution read Council voted to refer it to the Legislative Board for action.

Dr. Smith was recognized by the Chairman and he presented two Resolutions for Council consideration per instructions following his presentation of yesterday. The Resolutions are as follows:

Resolution No. 1

"WHEREAS, the Medical Association of Georgia believes that fee-for-service arrangement is conducive to the best interest of individual patients, and

WHEREAS, the Georgia Department of Public Health has recently discontinued all fee-for-service arrangements.

THEREFORE, BE IT RESOLVED, that the Medical Association of Georgia go on record as strongly endorsing the fee-for-service principle in the Community Hospital Psychiatric Program and other arrangements involving the direct medical treatment of patients in those communities where the private practitioners are willing to provide such services,

AND, FURTHER, that the Medical Association of Georgia urges that the Georgia Department of Public Health reinstate the fee-for-service arrangements as soon as possible."

Resolution No. 2

"WHEREAS, there has been a gradual and persistent effort on the part of certain federal and state agencies to provide increasing medical services not only to the medically indigent, but to the public at large, and

WHEREAS, there have been in many instances no guidelines to set forth what constitutes medical indigency, now

THEREFORE, BE IT RESOLVED, that the Medical Association of Georgia establish a subcommittee to work with the various agencies concerned to establish such guidelines, and to assure that persons not truly medically indigent would not receive such services."

On motion (Mercer-Andrews) it was voted to endorse the concept of the above resolutions, to investigate the problem of eligibility for these programs, and to refer this to the Executive Committee with the power to act.

In the above connection Dr. Scoggins made a motion that the Association wholeheartedly recommend that each hospital have an M.D. on its governing board as a voting member. This motion was seconded by Dr. Mauldin and was so approved.

June 1963 AMA Meeting Report

Dr. Chambers reported on the June 1963 AMA House of Delegates actions: (1) Composition of AMA Council on Medical Education and Hospitals; (2) Composition of the AMA Board of Trustees; (3) Interns and Residents Salaries being

paid from fees collected by the attending physician or out of fees collected under any type of medical-surgical insurance coverage; (4) 25% Rule deleted regarding proportion of foreign medical graduates to American and Canadian Medical School graduates in the approved internship programs; (5) AMA Pension Plan; (6) Drug Store Ownership by a physician; (7) Dispensing of Glasses by Ophthalmologists; (8) Drug Repackaging Companies; (9) Pharmaceutical Company Stock; (10) Hill-Burton Grants for Diagnostic and Treatment Centers; (11) Mental Health Legislation; (12) Health Professions Educational Assistance Act of 1963; (13) Opposition to Construction of New V. A. Hospitals; (14) Podiatry Study; (15) Refilling Prescriptions.

Southeastern States Hospitality Room: Dr. Chambers suggested that this room be open only at the Annual AMA meeting in June of each year. However, he asked for a supplemental appropriation not to exceed \$300.00 for the forthcoming meeting in Portland, December 1-4, 1963, because the Association is already committed for this. On motion duly made and seconded it was voted to appropriate the money with funds to be taken from the Contingent Fund. With regard to having the Hospitality Room open only at the Annual meeting in the future, a motion was made by Dr. Walker, and seconded by Dr. Mauldin, that Council is in favor of the Hospitality Room at the Annual Meeting only, but would leave the final decision to the AMA Delegates about having the room open at the Annual and Interim meetings. A final motion on this subject was made (Alexander-Scoggins) that this report be accepted and to thank the Delegates and commend them for the job they are doing.

GaMPAC Report

In the absence of Dr. Hatcher, Mr. Krueger gave the report as follows:

(1) MAG Endorsement: The following Resolution was read to Council:

Resolution

"WHEREAS, there is a great need for a strong political action committee in Georgia, and

WHEREAS, GaMPAC provides the mechanism through which this desirable objective may be accomplished,

NOW, THEREFORE, BE IT RESOLVED, that the Council of the Medical Association of Georgia does hereby go on record as endorsing the Georgia Medical Political Action Committee, and

BE IT FURTHER RESOLVED, that the Chairman of Council is hereby requested to seek endorsement of GaMPAC by the MAG House of Delegates at the 1964 Annual Session through his Annual Report to the House of Delegates." Council then voted to ask the Chairman of Council to seek endorsement of GaMPAC by the MAG House of Delegates.

(2) Appointment 2d District Chairman: Dr. W. P. Stoner, Sylvester, was suggested. On motion duly made and seconded it was voted to approve the appointment of Dr. Stoner as GaMPAC Chairman, for the 2nd District.

Health Insurance Council Liaison Committee Report

Dr. W. W. Moore, Chairman of the Health Insurance Council Liaison Committee, stated that the members of the Health Insurance Council, representing private insurance companies, want an avenue of communication with the county societies at a local level to advise the insurance carriers about health insurance, other than indemnity coverage, as to the insurance company's liability based on individual cases. Liaison between health insurance companies and physicians could be directed through a committee. After discussion, on motion (Jones-Brown) it was voted that the Health Insurance Council Liaison Committee, of which Dr. Moore is Chairman, be instructed to proceed with whatever is necessary to establish a Medical Insurance Liaison Committee composed of doctors and members of the Health Insurance Council, and in the process to maintain close contact with the Executive Committee, and that the Executive Committee then appoint such a committee to work with the insurance industry. Dr. Mauldin then recommended an amendment as follows: That this committee be authorized to draw up specific outlines as to the functions of the committee and submit these outlines to Executive Committee for approval. The motion with the amendment was approved by Council.

MAG Pension Plan

Chairman Simpson announced the appointment of the following as members of the Administrative Committee for the pension

plan: Dr. J. G. McDaniel, Dr. Virgil B. Williams, and Mr. Milton D. Krueger. The Resolution to be adopted is worded as follows:

Resolution

"RESOLVED, that pursuant to Section VI of the Retirement Plan of the Medical Association of Georgia the following three persons are hereby designated to serve as members of the Administrative Committee until further action of Council:

/S/ J. G. McDaniel, M.D.

/S/ Virgil Williams, M.D.

/S/ Mr. Milton D. Krueger "

On motion (Dillinger-Bohler) it was voted to approve the above Resolution.

Legislative Report

Mr. Krueger gave the report as follows:

(1) Podiatry—The committee appointed to meet with the Podiatry Association has scheduled a meeting on October 6, 1963.

(2) Anti-Child Abuse Legislation—The Executive Committee recommendation on this legislation was to refer it back to the Legislative Committee for rewrite and referral back to the Executive Committee. Council approved this action.

(3) Dr. Annis' Address before Georgia General Assembly—A date has been scheduled for January 22-23, 1964, for Dr. Annis' address before the General Assembly. Received for information.

(4) National Legislative Committee Report—Dr. Walker reported that the House Ways and Means Committee hearings might be held in October and that MAG is prepared for a call to present such testimony before the committee. Mr. Nelson, AMA Field Representative, discussed the testimony also.

(5) Osteopathy—After discussion on this subject, on motion (Walker-McKemie) Council voted to give the Executive Committee the power to act with the Legislative Board on the problem of osteopathy.

1963 MAG House of Delegates Actions Referred to Council

Dr. Simpson read the list of items referred to Council by the 1963 House of Delegates:

(1) Gubernatorial appointments to Board of Health: Dr. Dillinger stated that the Executive Committee is working on this item.

(2) Podiatry: The Legislative Report covered this item.

(3) Insurance coverage for patients and physicians: This information has been published in the *JMAG*.

(4) Financing local hospital construction other than by federal governmental means: There was discussion but no decision was reached.

(5) Better MAG attendance at AMA meetings: Publicity and encouragement were recommended.

(6) Urging MAG members to join AMA: A letter to MAG members who are not members of the AMA will be mailed and the President's Page in the *JMAG* will mention this.

(7) Urging MAA implementation of Kerr-Mills law: Dr. Mauldin stated that in his opinion as soon as money is available it will be implemented in Georgia according to the Governor.

(8) Use of Vice Presidents to assist President: The First Vice President has been made a voting member of the Executive Committee, and the President may use the Vice Presidents if necessary.

(9) MAG to work with industry, labor and farm organizations for closer liaison: Dr. Dillinger suggested that doctors in rural areas join the Farm Bureau. This information is to be included in a County Society Officers Newsletter.

Headquarters Office Report

Mr. Krueger reported on the revised Annual Session program. On motion duly made and seconded it was voted to approve the program as revised.

Old Business

(1) Georgia Association of Broadcasters Request: Dr. Bishop stated that the GAB had suggested a program of general health items for radio and TV broadcasts, which would cost the Association \$1,000. If Council approved this idea there was \$700.00 left in the Public Service Board budget, and he would need only \$300.00 to put on the program. On motion (Bishop-Jones) it was voted that the money be spent by MAG for this purpose with the \$300.00 to be taken from the Contingent Fund.

(2) Professional Conduct Problem: Mr. Krueger reported on a case and after discussion, on motion duly made and sec-

onded it was voted that the patient should be informed that no further action is possible.

(3) Report on Georgia Hospital-Medical Council Activity: Dr. Cowart reported on (1) Nursing Home Standards Program; and (2) Radiology Study Committee. This report was received for information.

New Business

(1) Kelly Letter re Distinguished Service Award: A thank you letter was read by Dr. Mauldin from Dr. Kelly upon receipt of the Distinguished Service Award. It was voted to publish this letter in the *JMAG*.

(2) Resolutions for AMA 1963 Portland Meeting: Dr. Mauldin asked for Resolutions to be presented at the AMA meeting in December, and suggested that a Resolution be submitted recommending that a doctor be a member of a hospital Board of Trustees. Dr. Mercer stated that he understood the AMA did not approve a doctor's being on a hospital Board of Trustees, and Dr. Chambers was asked to investigate the source of Dr. Mercer's information. On motion duly made and seconded Dr. Mauldin's recommended Resolution was approved.

(3) MSEA Membership for Moffett and Wooten: On motion (Mauldin-Dillinger) it was voted to approve the Executive Committee's recommendation that membership dues be paid for Mr. Moffett and Mrs. Wooten.

(4) Dorsey-Alston Letter: Dr. Simpson read a letter from the Dorsey-Alston Company which proposed certain revisions to improve the Life of Georgia plan. On motion (McDaniel-Walker) it was voted to refer this to the Insurance and Economics Board and ask for a report at the next Executive Committee meeting; and to empower the Executive Committee to act on this matter.

(5) Veterans Administration Problem: Dr. Williams reported on an indigent case referred to him by the V. A. for treatment for which he would receive \$3.00 each for three office visits. He refused to treat the patient under the circumstances. This report received for information.

(6) Date and Site of December Council Meeting: Dr. Eldridge invited Council to meet in Valdosta in December, and on motion it was voted to do so. The meeting dates are December 7-8, 1963.

There being no further business the meeting was adjourned at 12:25 p.m.

MAG EXECUTIVE COMMITTEE OF COUNCIL MEETING MINUTES

THE EXECUTIVE COMMITTEE of Council meeting was called to order at 1:17 p.m., September 28, 1963, at the Cloister Hotel, Sea Island, Georgia, by the President George R. Dillinger.

The invocation was given by President Dillinger.

The members in attendance were: George R. Dillinger, Thomasville; John T. Mauldin, Atlanta; Addison W. Simpson, Jr., Washington; Walker L. Curtis, College Park; John S. Atwater, Atlanta; J. G. McDaniel, Atlanta; and Virgil B. Williams, Griffin. Mr. Richard Nelson, Field Representative of the AMA was also present, as well as Mr. Milton D. Krueger and Mrs. Catherine Wooten, of the MAG staff.

Reading of Minutes

On motion duly made and seconded it was voted to dispense with the reading of the minutes, as copies had been mailed to the members before the meeting.

Treasurer's Report

Dr. Atwater gave the Treasurer's report and on motion duly made and seconded it was voted to accept the report as given.

Health Recodification Bill

Dr. Dillinger asked that this item be deferred until Dr. Williams was present to discuss it with the committee.

Medicare Claims

Dr. Mauldin reported on two claims:

(1) Claim for excision of hemangio-endothelioma—This claim had been discussed at the July Executive Committee meeting and Dr. Williams was asked to obtain a description of the operative procedure and whether it was done under local or general anesthesia, and present it at the next Executive Committee meeting so that a decision could be rendered. A fee of

THE ASSOCIATION / Continued

\$100.00 had been charged for the surgery. After discussion on this claim, on motion duly made and seconded, it was voted to recommend that \$75.00 be paid for the surgery.

(2) Claim for bilateral salpingectomy—This claim had been disallowed by the local and state review board twice and has been referred to the Executive Committee. A letter from the Office for Dependents' Medical Care was read by Dr. Mauldin, in which the intent seemed to be asking reconsideration of the claim. After discussion, on motion duly made and seconded, it was voted to pay this fee in compliance with the letter mentioned above, dated September 17, 1963.

Mental Health Committee Recommendations

In the absence of Dr. James Brawner, Chairman of the Mental Health Sub-committee, Mr. Krueger gave the report for him.

(1) *Yochem Report Recommendations*: The six items listed in the report submitted by Dr. Yochem following his attendance at the AMA National Congress of Mental Illness and Health, held in Chicago, October 4-6, 1962, and which had been referred to Executive Committee for study, had been considered by the Mental Health Subcommittee, at the Executive Committee's request. These six items are being implemented now or are in the process of being implemented.

Mr. Krueger then read the actions and recommendations of the Mental Health Subcommittee and the following action was taken on item II of Dr. Brawner's report:

"II. *Appointment of New Members to Mental Health Subcommittee*: In order to provide for rotation of members on this committee, the following procedure is respectfully submitted for approval: 'Each year at least three (3) new members, one of whom is a Past-President of the Georgia Psychiatric Association, shall be appointed to serve for three (3) years; and a Past-President of the G.P.A. shall be appointed chairman to serve for one year. The present committee, prior to the annual meeting of MAG in 1964, shall determine the length of service of each member for one, two or three years.'"

After discussion of item II, on motion duly made and seconded, it was voted to disapprove the appointment of a G.P.A. Past-President as chairman of the committee each year but to approve the rotation of members, as stated above, by the subcommittee.

"III. *Invitation of Guests to Council Meetings*: In order to enhance state level communication and mutual understanding between MAG and the State Department of Public Health, this committee recommends that Doctors John Venable and Addison Duval be invited to attend all Council meetings as guests without vote or official capacity."

A decision by the Executive Committee on item III was to invite Doctors Venable and Duval to attend any meeting they desired but no special invitation could be tendered.

"IV. *Report of Mental Illness Insurance Study Committee*: Mr. James Bentley, State Insurance Commissioner, and members of the committee to study Mental Illness Insurance, rendered a report in which the MAG Mental Health Committee concurred."

After discussion on item IV, on motion duly made and seconded it was voted to recommend to Council that it endorse the idea of insurance companies developing mental health illness policies, and to publish this information in *JMAG*.

Under item IV, Dr. Brawner's committee requested that consideration be given to the formation of "Insurance Utilization Committees" for protection of the insured and insurer, composed of MAG members, insurance company representatives, and representatives of the Georgia Hospital Association.

The Executive Committee was informed that this had been considered by the Health Insurance Council Liaison Committee, of which Dr. W. W. Moore is chairman, and would be reported on at Council meeting.

President Dillinger then called for a recess of this meeting at 2:05 p.m., until after the Council meeting recess, due to a shortage of time.

* * * * *

The Executive Committee was reconvened at 5:30 p.m. and then proceeded with the order of business.

Health Recodification Bill

Dr. Dillinger called on Dr. Williams, recently elected chair-

man of the State Board of Health, to discuss the suggested change in the composition of the Board of Health. Dr. Williams informed the Executive Committee that a meeting has been scheduled between the Executive Committee of the State Board of Health and the Chairmen of State Committees to discuss this matter, and that he would certainly follow the desires of the MAG to the best of his ability. Dr. Williams was asked to obtain copies of the Health Recodification Bill for members of the Executive Committee.

Legislative Report

Mr. Krueger, in Mr. Moffett's absence, discussed the following:

(1) *Anti-Child Abuse Legislation*: Summaries of proposed but not enacted Anti-Child Abuse in other states had been previously reviewed, and after discussion it was voted to refer this back to the Legislative Committee for study and report later to the Executive Committee.

(2) *Dr. Annis' Address before Georgia General Assembly*: A date for Dr. Annis to address a Joint Session of the General Assembly (January 22-23, 1964) has been cleared with the AMA office and plans are in the making for his visit to Atlanta.

Advisory Committee of Board of Examiners of Practical Nurses for Georgia Appointment

After discussion on the appointment, the following names were suggested: Charles T. Cowart, LaGrange, and Grady Coker, Canton. On motion duly made and seconded it was voted to submit the above nominated to the Governor for appointment to the Advisory Committee of the Board of Examiners of Practical Nurses for Georgia.

Headquarters Office Report

Mr. Krueger reported on the following:

(1) *Office Personnel Policies*: After reviewing the personnel policies the Executive Committee voted to adopt the policies as presented.

(2) *Long Range Project Meeting*: This item was deferred until the October Executive Committee meeting.

(3) *AMA-ERF*: As a follow-up to Mr. Nelson's request at a previous meeting, a committee of three members to work with the Fulton County Medical Society on the program of obtaining contributions from Atlanta firms to AMA-ERF, was appointed as follows: Carter Smith, Atlanta; Charles S. Jones, Atlanta; and J. G. McDaniel, Atlanta.

(4) *Georgia State Nurses Association Liaison Committee*: A letter from the Georgia State Nurses Association requesting a meeting between representatives of MAG and a liaison committee of the Georgia State Nurses Association was read. After discussion it was decided to ask the Secretary to contact Dr. Charles Eberhart with regard to his exploring the possibility of whether a committee is necessary for liaison with the nurses.

(5) *JMAG Subscription Rate*: At the request of the Editor of *JMAG* Mr. Krueger stated that Dr. Woody would like Executive Committee's opinion regarding an increase in the price of a Journal subscription from \$5.00 to \$7.00. On motion duly made and seconded it was voted to approve this recommendation effective January 1, 1964.

Old Business

The Executive Committee was informed about the following:

(1) Thank you letters for flowers were read from the family of Dr. W. F. Reavis and from Dr. Thomas W. Goodwin.

New Business

The following items of New Business were discussed:

(1) *Directory of Human Resources*: A letter from the Director Chairman of the proposed Directory of Human Resources Committee was read by Dr. Mauldin. A group of private agencies, departments of government, and individuals had met to discuss the possibility of publishing such a directory. The committee has requested that the Medical Association of Georgia consider such a directory and asked for a \$1,000 contribution toward such a goal. After discussion it was voted to ask Dr. John Bowen to investigate this project and advise the Executive Committee of its merits.

Due to the lateness of the hour, Chairman Dillinger recessed this portion of the Executive Committee meeting at 6:35 p.m.

until Sunday, September 29, 1963, after the adjournment of the Council meeting.

* * * * *

The Executive Committee meeting was reconvened at 12:35 p.m. on September 29, 1963, and the remaining business on the agenda proceeded.

(2) Governor Sanders' Letter: Governor Sanders acknowledged receipt of the nominations for appointment to the State Medical Board of Workmen's Compensation.

(3) Tenth Street, Business Association Request. A request for \$20.00 for Christmas decorations for the Tenth Street area was submitted. On motion duly made and seconded it was voted to pay the \$20.00 to the Tenth Street Business Association.

(4) Ninth and Tenth District Meeting with October Executive Committee Meeting: Members of the Ninth and Tenth District Medical Societies are meeting in Athens on October 20, 1963, to view "The Barnstormer," and Executive Committee agreed to meet on Sunday, October 20, at 10:00 a.m., in Athens. The meeting place is to be decided later. After adjournment of the October meeting the members will view the film with the Ninth and Tenth District members.

(5) MAG Annual Session Board Chairman: Mr. Krueger stated that Dr. Hydrick would like to be replaced as Chairman of the Annual Session Board. On motion duly made and seconded it was voted to ask the President and President-Elect to confer with Dr. Hydrick regarding the appointment of an Annual Session Board Chairman.

There being no further business the meeting was adjourned at 1:05 p.m.

MAG EXECUTIVE COMMITTEE OF COUNCIL MEETING MINUTES

THE OCTOBER EXECUTIVE COMMITTEE of Council meeting was called to order at 10:15 a.m., October 20, 1963, Center for Continuing Education, University of Georgia, Athens, Georgia, by the President and Chairman George R. Dillinger.

Members of the Executive Committee in attendance were: George R. Dillinger, Thomasville; J. G. McDaniel, Atlanta; Walker L. Curtis, College Park; John T. Mauldin, Atlanta; Thomas W. Goodwin, Augusta; Virgil B. Williams, Griffin; and Addison W. Simpson, Washington. Also present was Mr. James J. Segars, Director, Division of Medical Care, State Department of Family and Children Services; as well as Mr. Milton D. Krueger, Mr. James M. Moffett and Mrs. Catherine Wooten, of the MAG Staff.

Dr. Goodwin gave the invocation.

Reading of Minutes

Mr. Krueger reviewed the minutes of the September 28-29, 1963 Executive Committee and Council meetings. A rewording of the minutes in the Mental Health Subcommittee Report was corrected to read: "A Georgia Psychiatric Association Past President be appointed chairman each year, was disapproved." The former wording was "the Georgia Psychiatric Association Past President . . ." This change had been requested by the Chairman of the MAG Mental Health Subcommittee, Dr. James N. Brawner. No change in previous action was recommended but President Dillinger was asked to call Dr. Brawner to explain the committee's action. At the conclusion of the minutes review on motion (Mauldin-McDaniel) it was voted to approve the minutes.

Treasurer's Report

Mr. Krueger gave the Treasurer's report for Dr. Atwater, who could not attend this meeting. On motion duly made and seconded the report was approved as presented.

Committee Appointments

Dr. Mauldin read a list of suggested committee appointments for Executive Committee consideration:

(a) Weekly Health Column: Joseph E. Griffith, Marietta; W. L. McDougall, Atlanta; and James E. Anthony, Decatur. Appointments approved.

(b) School Child Health: M. D. Pittard, Toccoa, general practitioner. Appointment approved.

(c) Medicine-Religion: Frank P. Anderson, Jr., M.D., Augusta; John Duncan Farris, Waycross; C. D. Cabaniss, Atlanta; Curtis G. Hames, Claxton; Jos. S. Cruise, Atlanta; James B. Dunaway, Griffin; A. B. Dudley, Jr., Columbus; Sidney Isenberg, Atlanta; Samuel O. Poole, Gainesville; Noah D. Meadows,

Jr., Marietta; Jasper T. Hogan, Jr., Macon; M. Donald Pittard, Toccoa; Thomas E. Reeve, Jr., Carrollton; and Thomas Q. Spitzer, Atlanta. Appointments approved.

(d) State Department of Public Health Joint Council on Paramedical Education: W. B. Fackler, Jr., LaGrange; and John P. Wilson, Atlanta, as alternates. Appointment approved.

(e) Medical Indigency: This committee will function as a subcommittee under the MAG Board of Governmental Medical Services and the following were appointed per the minutes of the Council meeting, September 28-29, 1963: A. E. Hauck, Atlanta, Chairman; Charles C. Adair, Washington, Vice Chairman; Marvin Silverstein, Atlanta; Charles R. Smith, Columbus; James R. Winburn, Jr., Savannah; S. K. Brown, Augusta; Henry Jennings, Gainesville; and as alternates, T. R. Freeman, Savannah; Wm. A. Fuller, Augusta; R. H. Randolph, Athens; and A. G. LeRoy, Thomson. Appointments approved.

(f) Allied Medical Careers Club representatives: The GP representatives were reappointed: W. A. Mendenhall, Chamblee; and Floyd R. Sanders, Decatur.

Physician As Voting Member of Hospital Governing Board

Dr. Dillinger suggested that the AMA Delegates be requested to submit a Resolution to the AMA House of Delegates at the Portland meeting, approving the attitude that one or more physicians be members of Hospital Governing Boards, and on motion (McDaniel-Mauldin) this was approved. It was also suggested that President Dillinger put this information in a President's Page in the *JMAG* and that the information should be distributed to the hospitals in Georgia. Dr. Chambers is to draw up the Resolution and get Dr. Dillinger's approval before submission to AMA.

Medical Care Programs

Mr. James J. Segars, Director, Division of Medical Care, State Department of Family and Children Services, commended the Medical Director, Dr. Mauldin, for his work and the medical profession in Georgia for the success of the Kerr-Mills program in this state. He stated that there was a need for an MAA program and a medical care program for children, which would include a dental program. Possible criteria for MAA eligibility was discussed. Possible services would be: A hospitalization program identical to OAA; private nursing home care for six months where necessary following hospitalization, and after six months if income was not sufficient, the person might apply for OAA to obtain further nursing home care; limited physician services; and the possible inclusion of drugs and prostheses. He stated that the appropriation of more funds in 1964 would assist the promotion of the MAA program but he was not sure this would eventuate. He also stated that he felt that physicians should be paid for visits to nursing homes. The Executive Committee discussed several features of the program with Mr. Segars and received his report for information.

Mental Health Care In Georgia

Dr. Dillinger read a paragraph from the Milledgeville Study Committee Report which stated:

Long Range Recommendations

"The Advisory Committee and the appropriate legislative committee or committees should, as soon as possible, give consideration to the drawing up of legislation creating a State Department of Mental Health. Such Department of Mental Health shall administer the medical and physical care and the mental rehabilitation of patients in all public institutions charged with care and treatment of mentally ill persons. The Department will be responsible for the State's entire mental health program, including planning, program development, research, training and treatment. The Department will also be responsible for the development and maintaining of community psychiatric clinics throughout the State of Georgia.

"Supervising and responsible for the Department of Mental Health shall be a Board of Mental Health of ten members similar in composition and selection to the previously described Advisory Committee."

Dr. Dillinger then asked the members of the committee present: Bruce Schaefer, Toccoa; John Bell, Dublin; Corbett H. Thigpen, Augusta; and Rives Chalmers, Atlanta, to make statements. Dr. Schaefer was asked to begin the discussion on the Long Range Recommendations quoted above regarding the establishment of a State Department of Mental Health and general discussion ensued.

THE ASSOCIATION / Continued

Chairman Dillinger recessed the meeting at 1:05 p.m. for luncheon.

* * * * *

At 2:35 p.m. Chairman Dillinger reconvened the Executive Committee meeting and the discussion on mental health care in Georgia was resumed.

Dr. Schaefer recommended that Dr. Addison Duval be asked to meet with the Executive Committee to discuss the mental health program in Georgia. The Executive Committee approved this recommendation.

Dr. Bell then suggested that MAG recommend to the Governor that the Advisory Committee on Mental Health be reactivated and that new members be appointed with specific directions for their work.

Dr. Chalmers then stated that the reactivation of the Governor's Advisory Committee was a worthwhile step but that a stronger step would be the establishment of an Advisory Board on Mental Health Services to the Governor, to be composed of representative professional leaders in the state such as physicians, psychologists and ministers. This board would have the responsibility of advising the Governor on all mental health services in the state; and would serve in an advisory capacity to the State Board of Health and other state departments concerned with mental health.

It was suggested that the Executive Committee should meet with the State Board of Health to discuss matters of vital interest to the Board and the Medical Association of Georgia.

Health Recodification Bill H.B. 162

Mr. Moffett gave a report on the opinions of various members of the Association regarding the wording of certain sections of the Code. Dr. Mauldin presented the idea that the withdrawal of endorsement by MAG, due to the time element involved, would give the Association time to investigate the bill, and on motion (Mauldin-Goodwin) it was voted that the Association withdraw its support of the Health Recodification Bill 162 in its present form until such time as a final writing can be obtained. A resolution was then adopted, which read as follows:

Resolution

"WHEREAS, the Medical Association of Georgia previously endorsed H. B. 162 with the understanding that the composition of the Board of Health would not be disturbed, and

WHEREAS, this bill has been amended so that the Board of Health would be reorganized in such a manner as to make it unacceptable to the Medical Association of Georgia House of Delegates mandate, and

WHEREAS, there is present evidence to indicate that drastic reorganization of the Board will in fact remain a part of this bill, and

WHEREAS, there is mounting criticism of this bill from various sources in the Medical Association of Georgia, heretofore silent on this matter, and

WHEREAS, a formal criticism of the entire bill is presently contemplated for presentation to Council at its December meeting, and

WHEREAS, continued silence on the part of the Medical Association of Georgia will be interpreted by the proponents of this bill to mean that we will accept all portions of H. B. 162,

THEREFORE, BE IT RESOLVED, that MAG withdraw its endorsement of H. B. 162 until such time as an official Association position can be reached on the amended version of this bill, and until such time as the final draft of this bill is made."

Walker-Catoosa-Dade Resolution

Dr. Dillinger read a letter and resolution from the Walker-Catoosa-Dade County Medical Society which voiced opposition to the contemplated change in composition of the State Board of Health, as stated in H. B. 162. In view of the above action in the preceding Resolution regarding withdrawal of endorsement of H. B. 162, it was recommended that the Walker-Catoosa-Dade County Medical Society be informed of the withdrawal of support of the bill.

Meeting With State Board of Health

The Executive Committee referred to the former suggestion during the Mental Health Care in Georgia discussion, that a joint meeting of the MAG Executive Committee with the State Board of Health be held as soon as possible. Dr. Williams,

Chairman of the State Board of Health, is to determine the best time and place after a meeting on October 24, with the Board of Health, and will inform MAG Headquarters so that the meeting can be arranged.

Podiatry Committee Report

Mr. Krueger gave a report of the meeting held October 6 and read the six recommendations of the podiatrists. On further motion duly made and seconded it was voted to instruct Dr. Allman to meet with his committee and make recommendations to Council at the December meeting as to what procedures podiatrists should and should not do.

Headquarters Office Report

Mr. Krueger reported on the following:

(a) Long Range Project Meeting: Dr. Dillinger discussed several projects, in addition to the ones previously mentioned by Mr. Krueger, and the determination of the date and site of the meeting were deferred until the November Executive Committee meeting.

(b) Personnel changes in the MAG Headquarters office were discussed. This report was received for information.

Old Business

(a) Cornell University Automotive Crash Injury Research Program: This program had been previously approved by the Executive Committee but a letter to be signed by the President had been received from Cornell and the Executive Committee voted to refer this to Dr. Dillinger for approval. The mailing is to be done in November, 1963.

(b) Legislative Board Request for Clarification of Item referred by Council: At the September Council meeting a resolution was submitted which stated:

"Resolved that the governing body of any hospital, board of trustees, commission or other means of government shall not have the right to finally determine a medical issue or any issue by overriding the medical opinion or judgment.

"After hearing this Resolution read Council voted to refer it to the Legislative Board for action."

It was voted to inform the Legislative Board that the intention of the above resolution has been implemented by the proposal to submit a resolution to the AMA House of Delegates on this subject.

(c) Hypnosis Bill Clarification: At the September Council meeting the draft of the Hypnosis Bill submitted for approval was returned to the Legislation Committee for rewording to strengthen it. The Legislative Committee requested clarification of the action desired. After discussion, the Executive Committee voted to inform the Legislative Committee that the bill had again been reviewed, found satisfactory, and returned to the Legislative Committee for implementation.

New Business

(a) Candidates from MAG for AMA Boards, Councils or Committees: President Dillinger was asked to write Dr. Ernest B. Howard, of the AMA, with a copy to Mr. Richard Nelson, a list of names. Mr. Krueger was asked to consult with Drs. Mauldin, McDaniel, Williams and Curtis to obtain suggested names.

(b) U. S. Chamber of Commerce Meeting: Mr. Krueger read a letter of invitation to attend the U. S. Chamber of Commerce Public Affairs Conference, February 5-6, 1964, Washington, D. C. This item was deferred until the November Executive Committee meeting.

(c) Atlanta Diabetes Association: Dr. Dillinger stated he had been invited to attend the Atlanta Diabetes Association meeting but could not and would write the Association accordingly.

(a) Installation Ceremony of Emory University President: Dr. Dillinger stated he had been invited to attend the November 15, installation ceremonies for the new President of Emory University, and would make every effort to attend.

(e) Georgia State League for Nursing Meeting: Dr. Dillinger announced he was to address the Georgia State League for Nursing in Atlanta, October 21.

(f) State Board of Medical Examiners Letter: A letter from the State Board of Medical Examiners regarding a year's internship requirement by a medical school before a degree would be granted, and other pertinent data, had been received. This item was deferred until the November Executive Committee meeting.

There being no further business the meeting was adjourned at 5:55 p.m.

Index

Volume 52--1963

Month	Pages	Month	Pages	Month	Pages
January	1-52	May	199-236	September	387-422
February	53-94	June	237-308	October	423-458
March	95-154	July	309-348	November	459-498
April	155-198	August	349-386	December	499-540

AUTHOR INDEX

Key to letter abbreviations appearing before page numbers:

B—Book Review

C—Cancer Page

E—Editorial

H—Heart Page

L—Legal Page

M—Mental Health Page

Author	Page	Author	Page
Addison, B.A., M.D.	203, 322, B-416	Newman, Jim, Editor,	
Anthony, James E., Jr., M.D.	363	LaGrange High Clarion	E-332
Armstrong, B. W., M.D.	506	Newsom, Neal H., M.D.	425
Armstrong, Maj. Frederick S., M.C.	58	Nichols, Evans J., M.D.	393
Ayer, Darrell, M.D.	B-190	Norris, Jack C., M.D.	74
Bailey, Thomas E., M.D.	B-493	Oremland, Jerome D., M.D.	M-86
Biggs, Albert W., M.D.	351	O'Rourke, Donald E., M.D.	393
Bliven, Floyd E., M.D.	399	Osberg, James W., M.D.	432
Boszormenyi-Nagy, Ivan, M.D.	E-366	Osment, Lamar S., M.D.	436
Brawley, William G., M.D.	363	Owings, Richard S., M.D.	97
Brawner, James N., Jr., M.D.	B-492	Perdue, Garland D., Jr., M.D.	201
Bridges, H. Benton, M.D.	399	Perkins, Henry R., M.D.	E-110
Brown, George W., M.D.	E-181	Phillips, Richard H., M.D.	E-480
Brown, Lester A., M.D.	E-331	Powell, R. Waldo, M.D.	317, C-482
Bryant, Milton F., M.D.	B-303, 468	Raiford, Morgan B., M.D.	106
Burgstiner, Carson B., M.D.	101	Raines, Samuel L., M.D.	515
Burrell, Zeb, M.D.	354	Redd, Bryan L., Jr., M.D.	C-444
Chessick, Richard D., M.D.	E-217	Redd, Stephen S., M.D.	B-416
Claiborne, T. Sterling, M.D.	B-47	Ridley, John H., M.D.	B-147, E-439
Cohen, Sheldon B., M.D.	20, B-191	Riese, Hertha, M.D.	M-41
Conner, Joel D., M.D.	24	Robertson, Mason G., M.D.	H-374
Cox, J. L. D., M.D.	M-145	Rogers, Harrison L., Jr., M.D.	E-109
Craig, James B., M.D.	M-527	Rogers, James V., Jr., M.D.	317, C-482
Curtis, Earnest M., M.D.	425	Scardino, Peter L., M.D.	B-190, 208
Cutchin, Joseph H., Jr., M.D.	461	Scott, Harold George, Ph.D.	162
Dillinger, George R., M.D.	8	Sealy, Hugh K., M.D.	H-186
Dowda, F. William, M.D.	H-526	Searles, Paul W., M.D.	12
Dugdale, Marion, M.D.	351	Shackelford, Francis	L-413
Dunbar, Walter S., M.D.	H-484	Shanks, James Z., M.D.	B-48
Duval, Addison M., M.D.	M-300, M-487	Shea, P. C., Jr., M.D.	205
Ellington, Preston D., M.D.	B-492	Shepard, Duncan, M.D.	B-47
Elliot, John L., M.D.	H-43	Shirley, William C., M.D.	359
Ellison, Robert G., M.D.	171	Skobba, Joseph S., M.D.	B-415
Engler, Harold S., M.D.	501	Smith, Charles R., M.D.	M-414
Evans, Edwin C., M.D.	B-492	Smith, Ernest G., Jr., M.D.	E-79
Felder, Richard E., M.D.	B-416	Smith, J. Graham, Jr., M.D.	356
Fine, Robert M., M.D.	162	Smith, Martin H., M.D.	H-82
Fister, George M., M.D.	E-216	Steinhaus, John E., M.D.	396
		Sullivan, Robert D., M.D.	389
		Sylvester, Hart, M.D.	354
		Tager, Morris, M.D.	E-365
		Teabeaut, J. Robert II, M.D.	B-493
		Tippins, W. C., Jr.	177
		Todd, Charles E., M.D.	E-179
		Trotter, Michael H.	L-486
		Underwood, Paul, M.D.	461
		Wammock, Hoke, M.D.	C-81
		Watkins, Elton, Jr., M.D.	389
		Watters, T. A., M.D.	63
		Wenger, Nanette Kass, M.D.	210, H-223
		Whisnant, Charles L., M.D.	B-415
		Whitaker, Lloyd T.	L-225
		Wiggins, Roy A., Jr., M.D.	B-191
		Wight, Robert P., Jr.,	
		Senior Medical Student	210
		Wilber, Joseph A., M.D.	E-79
		Wilds, Preston Lea, M.D.	24
		Wills, S. Angier, M.D.	157
		Woods, Alexander H., M.D.	512
		Yauger, John T., M.D.	H-337
		Zwiren, Gerald T., M.D.	B-47, B-302

SUBJECT INDEX

Key to letter abbreviations appearing before page numbers:

- B—Book Review
- C—Cancer Page
- E—Editorial
- H—Heart Page
- L—Legal Page
- M—Mental Health Page

— A —

ABSTRACTS

- Abstracts by Georgia Authors
88, 192, 304, 380, 417, 453, 530

ADOLESCENCE

- Impasse in Adolescence (Cox) M-145
- Learning Problems in Adolescence
(Oremland) M-86

ALCOHOLISM

- Carphenazine in the Withdrawal Phase
of Acute Alcoholism (Fox) 167

AMENORRHEA

- Amenorrhea of Pituitary Origin
(Shirley) 359

AMERICA—MORAL CLIMATE

- Let's Start Raising Hell (Jones) 30

AMERICAN MEDICAL ASSOCIATION

- AMA Statement of Principles on
Mental Health M-227
- See You in Atlantic City (Fister) E-216

ANESTHESIOLOGY

- Evaluation of Opiates for Pain and
Premedication (Steinhaus and Lee) 396
- Halothane (Fluothane) E-405
- Preanesthetic Evaluation of Blood Loss
in the Traumatized Patient
(Keown and Miller) 473
- Selection of Agents and Techniques in
Anesthesia (Searles) 12
- The Use of Promazine, Meperidine,
and Scopolamine in Labor and
Delivery (Burgstiner) 101
- Transvaginal Anesthesia in Obstetrics
(Conner and Wilds) 24

ANNUAL SESSION (also see MAG)

- An Ode to the 109th Annual Session
(Galloway) E-108

ART OF MEDICAL PRACTICE

- Scientists, Mechanics, and Healers
(Gullatt) 71

ATYPICAL ACID FAST BACILLI

- The Battey Strain of Atypical Acid
Fast Bacilli (Neely) E-37

AUTOMOTIVE CRASH INJURY STUDY

- America's Number One Epidemic E-521

— B —

BIOLOGICAL CLOCK

- The Biological Clock in Clinical Medicine
(Hutchinson) E-403

BONE DISEASE

- Bone Disease of Renal Origin (Miller) 174

— C —

CALENDAR OF MEETINGS

- 77, 178, 220, 292, 334, 450, 475, 529

CANCER

- A Simplified Technique for Cancer
Infusion Chemotherapy
(Addison and Jennings) 203
- Cancer of the Gallbladder (Letton) C-45
- Cancer of the Lung (King) C-141
- Carcinoma of the Tongue, Report of a
Group of Patients (Wills) 157
- Current Status of Mammography
(Rogers and Powell) C-482
- Deus Ex Machina (Mabon) C-525
- Diagnosis and Treatment of Carcinoma
of the Prostate from a G.P.
Viewpoint (Raines) 515

- Enzymes and Cancer Diagnosis
(Galambos) C-296
- Exfoliative Cytology (Ridley) E-439
- Gastric Carcinoma (Wammock) C-81
- Malignant Bone Tumors in Children
(Funk) C-335
- Multiple Myeloma (Freedman) C-371
- Office Cancer Detection Center
(Letton) C-184
- Selection of Patient and Drug for
Cancer Chemotherapy
(Watkins and Sullivan) 389
- Smoking and Bronchogenic Carcinoma
(Godwin) E-36
- The Clinical Diagnosis of Ovarian
Malignancies (McCain) C-409
- The Role of Radiation Therapy in the
Management of Malignant Diseases
(Redd) C-445

CARDIAC ARRHYTHMIA

- Paroxysmal Tachycardias in Infants
(Wenger) H-223

CARDIOVASCULAR SYSTEM

- Acute Idiopathic Pericarditis, A
Continuing Diagnostic Problem
(Armstrong) 58
- Coarctation of the Aorta (Hudgins) H-298
- Cyanosis (Robertson) H-374
- Endocardial Sclerosis (Smith) H-82
- Evaluation of Changes in the Pulmonary
Circulation by Chest Radiography
(Gay) H-447
- Evaluation of Methyclothiazide Therapy
for Angina Pectoris
(Wenger, Flint, and Wight) 210
- Paroxysmal Tachycardias in Infants
(Wenger) H-223
- Patent Ductus Arteriosus (Yauger) H-337
- Prevention of Pulmonary Embolism
(Elliott) H-43
- Pure Pulmonary Stenosis (Sealy) H-186
- Renovascular Hypertension (Bryant) 468
- Shock and the Vasopressor Agents E-477
- The Diagnosis of Interatrial Septal
Defect (Minor) H-411
- The Diagnosis of Tetralogy of Fallot
(Dowda) H-526
- The Natural History of Isolated
Ventricular Septal Defect (Moore) H-143
- The Monk Study (Wilber) E-79
- Thrombosis of Aneurysms of the
Abdominal Aorta (Perdue) 201

CHEMOTHERAPY

- A Simplified Technique for Cancer
Infusion Chemotherapy
(Addison and Jennings) 203
- Selection of Patient and Drug for
Cancer Chemotherapy
(Watkins and Sullivan) 389

CHIROPRACTOR LICENSURE

- "Arkansas Chiropractors' Licenses
Revoked" (Moore) L-339

CHRONIC STASIS ULCERS

- Surgical Correction of Chronic
Stasis Ulcer of Long Duration,
A Case Report (Shea) 205

COLLEGE STUDENT PROBLEMS

- Problems of the Average College
Student (Lott) M-188

CONTRACEPTIVES

- Oral Contraceptives in the
Immediate Puerperium
(Curtis, Newsum, and Grant) 425

COUNTY SOCIETY OFFICERS

- 133, 156, 310, 424

CURRENT CLINICAL CONCEPTS

- 49, 149, 229, 345, 489

CYANOSIS

- Cyanosis (Robertson) H-374

CYTOLOGY

- Exfoliative Cytology (Ridley) E-439

— D —

DEATHS

- Armistead, Isaac Grant 419
- Bailey, Lucius A. 454
- Baird, James B. 50
- Barker, Homer Lumpkin 494
- Belcher, David Pearce 306
- Bishop, Everett L. 454
- Boland, J. H. 230
- Copeloff, M. B. 194
- Davis, Edgar Brown 50
- DeVaughn, Nathan M., Sr. 90
- Ezzard, W. P. 151

- Faulkner, John Asa, Jr. 151
- Grove, Lon Woodfin 532
- Guthrie, Nim J. 494
- Hailey, Hugh Edward 151
- Holton, Cornelius Fulmer 346
- Johnson, Roy L. 346
- Kelley, Albert J. 419
- Kelley, Luther H. 306
- Land, Polk Sanders 454
- Leaphart, J. A. 346
- Major, Robert C. 346
- Mathews, Thomas V. 454
- Mayher, William Edgar, Jr. 381
- Meeks, Jesse L. 151
- Mixon, Joyce F., Sr. 151
- Moseley, Earle E. 230
- Neill, Frank K. 419
- Reavis, W. F. 454
- Rollins, John Calvin 532
- Rosenberg, Herbert J. 381
- Skipper, William Groover 230
- Thurston, John A. 381

DERMATOLOGY

- Aging Skin, The Changes in Covered
and Exposed Dermis (Smith) 356
- Straw Itch Mite Dermatitis
Caused by Pyemotes Ventricosus
(Fine and Scott) 162
- Topical Treatment for Skin Diseases
(Osment) 436

DIET

- The Monk Study (Wilber) E-79

DRUGS

- Carphenazine in the Withdrawal Phase
of Acute Alcoholism (Fox) 167
- Evaluation of Opiates for Pain and
Premedication (Steinhaus and Lee) 396
- Serious Toxicologic Reaction to Some
Commonly Used Drugs (Mullins,
Burrell, Sylvester, and Gardner) 354
- The Use of Promazine, Meperidine,
and Scopolamine in Labor and
Delivery (Burgstiner) 101

— E —

EDITORIALS

- America's Number One Epidemic 521
- An Ode to the 109th Annual Session
(Galloway) 108
- Between a Rock and a Hard Place 294
- Could This Be Yours? (Perkins) 110
- Diagnostic Radiation and Early
Pregnancy (Brown) 181
- Exfoliative Cytology (Ridley) 439
- Frank H. Neely Nuclear Research
Center (Godwin) 329
- Freedom With Responsibility
(Newman) 332
- From Little Acorns 404
- Gastric Freezing, New Treatment for
Peptic Ulcer Diathesis (Todd) 179
- Georgia School for the Deaf (Brown) 332
- Grief (Phillips) 480
- Halothane (Fluothane) 405
- "It Is Better to Light One Candle . . ." 37
- M.A.A. Expansion of Georgia
Kerr Mills 180
- Measles Immunization 293
- Medicine and Religion (McCleve) 522
- Mrs. W. Bruce Schaefer Appointed
State Welfare Director 78
- New Aspects of Therapy for Severe
Pancreatitis (Rogers) 109
- Operation Hometown 330
- Oxygen Therapy 441
- Psychotherapy with the Family in
Schizophrenia
(Boszormenyi-Nagi and Framo) 366
- "See You in Atlantic City" (Fister) 216
- Shock and Vasopressor Agents 477
- Smoking and Bronchogenic Carcinoma
(Godwin) 36
- The Barnstormer 478
- The Battey Strain of Atypical Acid
Fast Bacilli (Neely) 37
- The Biological Clock in Clinical
Medicine (Hutchinson) 403
- The Identification of "Pseudoneurotic"
or "Borderline" Schizophrenic Patients
in General Medical Practice
(Chessick) 218
- The Merits of a Gift 440
- The Monk Study (Wilber) 80
- The Role of the Thymus Gland (Tager) 365
- The Technique of Radioisotope
Photoscanning (Smith) 79
- Typhoid Fever (Friedewald) 215

EMPHYSEMA

- The Etiology of Pulmonary Emphysema
(Dunbar) H-484

ENZYMES

- Enzymes and Cancer Diagnosis
(Galambos) C-296

— F —

FOREIGN BODY REMOVAL

- Use of Magnetic Force in Removing a
Metallic Foreign Body (Tippins) 177

FREEDOM FOUNDATION AWARD

EDITORIAL

- Freedom with Responsibility
(Newman) E-332

— G —

GALLBLADDER

- Cancer of the Gallbladder (Letton).....C-45

GA&PAC

- Between a Rock and a Hard Place.....E-294
The BarnstormerE-478

GASTRIC HYPOTHERMIA

- Gastric Freezing, New Treatment for
Peptic Ulcer Diathesis (Todd)E-179

GASTRO-INTESTINAL TRACT

- Gastric Carcinoma (Wammock).....C-81
Gastric Freezing, New Treatment for
Peptic Ulcer Diathesis (Todd).....E-179

GEORGIA HOSPITAL-MEDICAL COUNCIL

- From Little AcornsE-404

GEORGIA SCHOOL FOR THE DEAF

- Georgia School for the Deaf (Brown)....E-331

GERIATRICS

- Aging Skin, The Changes in Covered
and Exposed Dermis (Smith).....356
MAA Expansion of Georgia
Kerr-MillsE-180

GRIEF

- Grief (Phillips)E-479

GYNECOLOGY

- Amenorrhea of Pituitary Origin
(Shirley)359
The Clinical Diagnosis of Ovarian
Malignancies (McCain)C-409

— H —

HALOTHANE

- Halothane (Fluothane)E-405

HEMATOLOGY

- Control of Abnormal Prostatic
Bleeding (Biggs and Dugdale)351
Multiple Myeloma (Freedman)C-371

HOW WELL ARE WE TELLING OUR STORY?

- 11, 66, 144, 170, 214, 299, 342, 358, 392

HYPOTHERMIA

- Hypothermia in General Surgery
(Addison and Jennings)322

— I —

IMMUNOLOGY

- Measles ImmunizationE-293
The Role of the Thymus Gland
(Tager)E-365
Typhoid Fever (Friedewald)E-215

INFECTIOUS

- Typhoid Fever (Friedewald)E-215

INSURANCE

- Insurance Coverage of Mental Illness...M-451

INTERNAL MEDICINE

- Peptic Ulcer: Low Ailment on the
Totem Pole? (Hock)311

— K —

KERR-MILLS

- MAA Expansion of Georgia
Kerr-MillsE-180

KIDNEY

- Bone Disease of Renal Origin (Miller)...174

— L —

LEUKEMIA

- Leukemia (Huguley)C-221

LUNG

- Cancer of the Lung (King).....C-141
The Etiology of Pulmonary Emphysema
(Dunbar)H-484

— M —

MAMMOGRAPHY

- Current Status of Mammography
(Rogers and Powell)C-482
Experiences with Mammography at
Emory University Hospital
(Rogers and Powell)317

MEASLES

- Measles ImmunizationE-293

MEDICAL ASSOCIATION OF GEORGIA

- Annual Session—1963
Candid Camera286
Committees130
Guest Speakers115
Information112
Official Call111
Official Proceedings243
1st Session, House of Delegates
Sunday, May 5, 1963244
2nd Session, House of Delegates
Wednesday, May 8, 1963248
General Business Session
Sunday, May 5, 1963288
General Business Session
Monday, May 6, 1963289
General Business Session
Wednesday, May 8, 1963290
President's Address and President
Elect's Address289
Program124
Voting Rules131
Committees
Annual Session253
Blood Banks198, 261
Cancer285
Constitution and Bylaws272, 495
Crippled Children263
Disaster Medical Care264
Finance265
Geriatrics283
Headquarters Office497
Hospital Medical Council254
Hospital Activities261
Hospital Relations262
Insurance and Economics52, 275
Journal MAG276
Kerr-Mills254, 278
Legislation275
Maternal-Infant Welfare264
Medical Education198, 232, 279
Medicare254
Mental Health281, 456
Occupational Health
Professional Conduct268
Public Health265
Public Service280, 281
Rehabilitation
Rural Health232
School Child Health
Special Activities283
Weekly Health Column281
Woman's Auxiliary to MAG283
Woman's Auxiliary Liaison268
Council Meetings
December 8, 196292
March 23, 1963233
May 4, 1963347
May 8, 1963348
June 8, 1963383
September 28, 1963534
Executive Committee of Council Meetings
December 8, 196291
January 19, 1963153
February 17, 1963196
March 23, 1963232
April 15, 1963307
May 8, 1963348
June 8, 1963382
July 17, 1963420
August 15, 1963497
September 28, 1963537
October 20, 1963539
New Members of MAG
139, 218, 242, 373, 446, 476
Officers and Committees54
Personals
51, 90, 152, 195, 231, 306,
346, 381, 419, 455, 495, 533
President's Letter
(Goodwin)39, 140, 183
(Dillinger)295, 333, 369, 407, 443, 481, 523
Roster—See Special Supplement
Societies
50, 90, 151, 194, 230, 306,
346, 381, 419, 455, 494, 532

MEDICAL EDUCATION

- The Merits of a Gift.....E-440

MEDICAL LEGAL PROBLEMS

- A Surgeon's Responsibility (Moore).....L-84
Medical Reports in Administrative
Proceedings (Shackelford)L-413
The Right of Privacy (Whitaker)L-225

MEDICAL LEGISLATION

- Between a Rock and a Hard PlaceE-294
Georgia's New Youth Bill (Trotter)....L-486
MAA Expansion of Georgia
Kerr-MillsE-180
Operation HometownE-330
The BarnstormerE-478

MENTAL HEALTH

- Action for Mental HealthM-341
AMA Statement of Principles on
Mental HealthM-227
Depressions in Disguise (Watters)63
Evolution in Mental Health (Smith) M-414
Impasse in Adolescence (Cox)M-145
Insurance Coverage of Mental Illness M-451
Learning Problems in Adolescents
(Oremland)M-86
New Bournes in the Psychotherapy
of Antisocial Children (Riese)M-41
Plans for Georgia's New Mental
Health Program (Duval)M-300
Problems of the Average College
Student (Lott)M-188
Progress Report from Milledgeville
State Hospital (MacKinnon)M-376
Psychotherapy with the Family in
Schizophrenia
(Boszormenyi-Nagy and Framo)E-366
The Identification of "Pseudoneurotic"
or "Borderline" Schizophrenic Patients
in General Medical Practice
(Chessick)E-217
The Need for Mental Health Personnel
in Georgia (Duval and Holland)M-487
The Role of the Physician in Community
Mental Health (Osberg)432
Voluntary and Other Routine Admissions
to Milledgeville State Hospital
(Craig)M-527

MILLEDGEVILLE STATE HOSPITAL

- Progress Report from Milledgeville
State Hospital (MacKinnon)M-376
Voluntary and Other Routine Admissions
to Milledgeville State Hospital
(Craig)M-527

— N —

NEUROSURGERY

- Deus Ex Machina (Mabon).....C-525

NUCLEAR RESEARCH

- The Frank H. Neely Nuclear Research
Center (Godwin)E-329

— O —

OBSTETRICS

- Diagnostic Radiation and Early
Pregnancy (Brown)E-181
Fetal Distress (Underwood,
Hester, and Cutchin)461
Oral Contraceptives in the Immediate
Puerperum (Curtis, Newsom,
and Grant)425
Rupture of the Pregnant Uterus,
A Review of Nineteen Cases
(O'Rourke and Nichols)393
The Use of Promazine, Meperidine, and
Scopolamine in Labor and Delivery
(Burgstiner)101
Transvaginal Anesthesia in Obstetrics
(Conner and Wilds)24

OMPHALOCELE

- An Unusual Complication Associated
with Omphalocele
(Anthony and Brawley)363

OPHTHALMOLOGY

- Ocular Tonometry (Raiford)106

OPIATES

- Evaluation of Opiates for Pain and
Premedication (Steinhaus and Lee)396

ORTHOPEDICS

- Acute Hematogenous Osteomyelitis
(Bridges, Bliven, Harkess)399
Congenital Anomalies Associated with
Clubfoot (Kite)429
Malignant Bone Tumors in Children
(Funk)C-335
Open Reduction of Acetabular
Fractures (Floyd)104
Scoliosis Trouble (Flinchum)67

OSTEOMYELITIS

- Acute Hematogenous Osteomyelitis
(Bridges, Bliven, and Harkess)399

OTOLARYNGOLOGY

- Could This Be Yours? (Perkins)E-110
Vertigo-Differential Diagnosis and
Treatment (Armstrong)506

OTORHINOLARYNGOLOGY

- Simplified Approach to Otitis Externa
(Jenkins) 319

OXYGEN THERAPY

- Oxygen Therapy E-441

— P —**PANCREATITIS**

- New Aspects of Therapy for Severe
Pancreatitis (Rogers) E-109

PEDIATRICS

- New Bournes in the Psychotherapy of
Antisocial Children (Riese) M-41
Optimal Ages for Elective Surgical
Procedures in Infants (Lynn) 55
Paroxysmal Tachycardias in Infants
(Wenger) H-223
Recent Advances in Pediatric
Surgery (Owings) 97
Recognition of Thoracic Surgical
Emergencies in Infants
(Laupus and Ellison) 171
The Management of Acute Surgical
Problems in Children (Lynn) 3

PEPTIC ULCER

- Peptic Ulcer: Low Ailment on the
Totem Pole? (Hock) 311

PERICARDITIS

- Acute Idiopathic Pericarditis,
A Continuing Diagnostic Problem
(Armstrong) 58

PHYSICIAN COMMUNICATION

- "It Is Better to Light One Candle" E-37
The Barnstormer E-478

PHYSICIAN'S BOOKSHELF

- Books Received
47, 147, 190, 302, 343, 415, 492
Books Reviewed
A Handbook of Psychiatric Treatment
in Medical Practice 492
(Kline and Lehmann)
Bray's Clinical Laboratory Methods
(Bauer, Toro, and Ackermann) 493
Clinical Metabolism of Body Water
and Electrolytes (Bland) 415
Clinical Pathology, Application, and
Interpretation (Weils) 493
Correlative Neuro-Anatomy and
Functional Neurology
(Chusid and McDonald) 148
Counseling in Medical Genetics
(Reed) 492
Current Therapy (Conn) 303
Diagnosis in Clinical Obstetrics
(Lennon) 303
Doctor and Patient and the Law
(Stetler and Moritz) 302
Fundamentals of Plastic Surgery and
Their Surgical Applications
(McGreggor) 343
Gastroenterology (Backus) 343
Gynecology (Persons and Sommers) 191
Gynecology and Obstetrics (Huffman) 47
Handbook of Pediatric Medical
Emergencies (DeSanctis and Varga) 492
Handbook of Pediatrics
(Silver, Kempe, and Bruylant) 416
Malpractice Law Dissected for
Quick Grasping (Cusumano) 147
Medical Laboratory Technology
(Lynch, etc.) 344
Medical Resident's Manual
(Flood, Kennedy, and Grace) 190
Modern Clinical Psychiatry (Noyes) 415
Novak's Gynecologic and Obstetric
Pathology (Novak and Woodruff) 147
Pathology of the Lung (Spencer) 302
Pediatric Cardiology (Nadas) 492
Pediatric Surgery (Swenson) 302
Peripheral Vascular Diseases
(Allen, Barker, Hines) 47
Physiology of the Circulation in
Human Limbs in Health and Disease
(Shepherd) 303
Postpartum Psychiatric Problems
(Hamilton) 416
Preventive Pediatrics (Harper) 493
Principles of Internal Medicine
(Harrison, Adams, Bennett, Resnick,
Thorn, and Wintrobe, Editors) 48
Psychological Development in Health
and Disease (Engel) 191
Results of Surgery for Peptic Ulcer
(Postlethwait and Thoroughman) 493
Surgery (Warren) 416
Surgery in World War II, Activities
of Surgical Consultants
(Medical Dept., U.S. Army) 47

- Surgery of the Ambulatory Child
(Redo) 47
Surgical Practice of the Lahey Clinic
(Staff Lahey Clinic) 344
Synopsis of Neurology (Forster) 343
Synopsis of Obstetrics (McLennan) 302
Synopsis of Pediatrics (Hughes) 415
Synopsis of Roentgen Signs
(Meschan) 147
Textbook of Pathology with Clinical
Application (Robbins) 190
The Epic of Medicine (Marti-Ibanez) 190
The Human Adrenal Cortex
(Currie, Symington, and Grant) 191

PSYCHIATRY

- Current Role of Hypnosis in Medicine
(Cohen) 20
Grief (Phillips) E-479
New Bournes in the Psychotherapy of
Antisocial Children (Riese) M-41

PSYCHOTHERAPY

- New Bournes in the Psychotherapy
of Antisocial Children (Riese) M-41
Psychotherapy with the Family in
Schizophrenia
(Boszormenyi-Nagi and Framo) E-366

PULMONARY EMBOLISM

- Prevention of Pulmonary Embolism
(Elliott) H-43

— R —**RADIATION INJURY**

- Biological Dosimetry in Radiation
Injury (Woods) 512

RADIOISOTOPE SCANNING

- Radioisotope Organ Scanning (Ihnen) 465
The Technique of Radioisotope
Photoscanning (Smith) E-79

RADIOLOGY

- Current Status of Mammography
(Rogers and Powell) C-482
Diagnostic Radiation and Early
Pregnancy (Brown) E-181
Evaluation of Changes in the Pulmonary
Circulation by Chest Radiography
(Gay) H-447
Experiences with Mammography at
Emory University Hospital
(Rogers and Powell) 317
The Role of Radiation Therapy in the
Management of Malignant Diseases
(Redd) C-445
The Technique of Radioisotope
Photoscanning (Smith) E-79

REACTIONS TO DRUGS

- Could This Be Yours? (Perkins) E-110

RELIGION AND MEDICINE

- Medicine and Religion (McCleve) E-522

— S —**SHOCK**

- Shock and Vasopressor Agents E-477

SMOKING

- Smoking and Bronchogenic
Carcinoma (Godwin) E-36

SOCIALIZED MEDICINE

- Socialized Medicine (Harkess) 325

STAPHYLOCOCCUS

- A Plan for Concerted Attack on the
Staphylococcus (Norris) 74

STATE WELFARE DIRECTOR

- Mrs. W. Bruce Schaefer Appointed
State Welfare Director E-78

STRAW ITCH MITE

- Straw Itch Mite Dermatitis Caused by
Pymotes Ventriscus
(Fine and Scott) 162

SURGERY

- A Surgeon's Responsibility (Moore) L-84
An Unusual Complication Associated
with Omphalocele
(Anthony and Brawley) 363
Arterioesenteric Duodenal Obstruction
(Engler, Mann, and Moretz) 501
Carcinoma of the Tongue, Report of a
Group of Patients (Wills) 157

- Hypothermia in General Surgery
(Addison and Jennings) 322
Optimal Ages for Elective Surgical
Procedures in Infants (Lynn) 55
Recent Advances in Pediatric Surgery
(Owings) 97
Recognition of Thoracic Surgical
Emergencies in Infants
(Laupus and Ellison) 171
Surgical Correction of Chronic Stasis
Ulcer of Long Duration,
A Case Report (Shea) 205
The Management of Acute Surgical
Problems in Children (Lynn) 3
Thrombosis of Aneurysms of the
Abdominal Aorta (Perdue) 201

— T —**THERAPY**

- A Plan for Concerted Attack on the
Staphylococcus (Norris) 74
Bone Disease of Renal Origin (Miller) 174
Carphenazine in the Withdrawal Phase
of Acute Alcoholism (Fox) 167
Evaluation of Methyclothiazide Therapy
for Angina Pectoris
(Wenger, Flint, and Wight) 210
New Aspects of Therapy for Severe
Pancreatitis (Rogers) E-109
Simplified Approach to Otitis Externa
(Jenkins) 319
Topical Treatment for Skin Diseases
(Osment) 436

THYMUS

- The Role of the Thymus Gland
(Tager) E-365

THYROID

- Myxedema and Coma (Dillinger) 8

TONGUE

- Carcinoma of the Tongue, Report of a
Group of Patients (Wills) 157

TONOMETRY

- Ocular Tonometry (Raiford) 106

TOXICOLOGY

- Serious Toxicologic Reaction to Some
Commonly Used Drugs (Mullins,
Burrell, Sylvester, and Gardner) 354

TRAUMA

- Preanesthetic Evaluation of Blood Loss
in the Traumatized Patient
(Keown and Miller) 473

TUBERCULOSIS

- The Battey Strain of Atypical Acid Fast
Bacilli (Neely) E-37

TYPHOID FEVER

- Typhoid Fever (Friedewald) E-215

— U —**UROLOGY**

- Control of Abnormal Prostatic Bleeding
(Biggs and Dugdale) 351
Diagnosis and Treatment of Carcinoma
of the Prostate from a G.P.
Viewpoint (Raines) 515
Obstruction of the Male Urethral Meatus
(McKenzie and Scardino) 208
Renovascular Hypertension (Bryant) 468

— V —**VASOPRESSOR AGENTS**

- Shock and Vasopressor Agents E-477

VERTIGO

- Vertigo—Differential Diagnosis and
Treatment (Armstrong) 506

— W —**WOMAN'S AUXILIARY TO THE MAG**

- Organization 135
Roster—See Special Supplement
Thirty-Eighth Annual Meeting
President's Invitation 134
Program 137
Rules 136
Welcome to Georgia's Golden Isles 134

WORKMAN'S COMPENSATION FEES

- 1963 Revised Workman's Compensation
Average Schedule of Fees 212



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